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**How can we Improve Self-Care Practices and Reduce Burnout within New Zealand and Australian
Psychologists? Examining Self-Compassion and its Link to Self-Care and Burnout.**

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Abstract

The demanding nature of psychologists' work and their exposure to distressing content, puts them at high risk of experiencing stress outcomes. Self-care is widely accepted as important for preventing stress outcomes such as burnout; however, surprisingly few studies have investigated the link between self-care and burnout among psychologists. Further, despite ethical imperatives to engage in self-care, psychologists tend to have a chronic disregard for their own needs and limited research has investigated factors that increase psychologists' engagement in self-care. One promising factor that may enhance self-care and buffer burnout is self-compassion. Prior research within other helping professionals has linked self-compassion with promoting self-care and reducing burnout. However, almost no research has investigated the benefit of self-compassion for psychologists or considered the relationships between these three factors. This research explored self-compassion's relationship with self-care and burnout in psychologists, as well as whether self-compassion was a moderator of the relationship between self-care and burnout. Currently registered and practicing New Zealand and Australian psychologists ($n = 197$) were recruited through convenience sampling. Hierarchical regression analyses indicated that self-compassion had a significant, positive relationship with both professional and personal self-care in psychologist and that both self-compassion and self-care had significant, negative associations with burnout. Psychologists with greater self-compassion tended to have higher engagement in both professional and personal self-care along with lower levels of burnout. Moderation analysis showed that self-compassion was also a significant moderator of relationship between self-care and burnout, such that self-compassion strengthened the negative relationship that self-care had with burnout in psychologists. Specifically, as psychologists' level of self-compassion gets higher, the negative relationship between self-care and burnout gets stronger. These results highlight self-compassion as a valuable resource for enhancing self-care practices and buffering burnout within psychologists. This research extends the finding that self-compassion is positively associated with self-care to a population

of New Zealand and Australian psychologists, and it provides an initial foundation for new ways of looking at the relationship between self-care and burnout with respect to self-compassion.

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Chapter 1: Introduction

The mental health systems in both New Zealand and Australia are under increasing pressure to cater to the heightened demand for mental health services (Australian Psychological Society, 2022, June 20; Spence, 2022, May 19). The decade prior to 2017 saw a 73% increase in individuals accessing mental health and addiction services within New Zealand (Te Pou o te Whakaaro Nui, 2018). This preceded the COVID-19 pandemic (Spence, 2022, July 28), which has only increased demand for mental health support (Australian Psychological Society, 2022, June 20; Spence, 2022, June 25). Since June 2021, the number of psychologists who could not take on new clients (due to service demand) increased from 1 in 5 (22%) to 1 in 3 (33%) in Australia (Soit, 2023). Simultaneously, in New Zealand, 8.8% of adults and over 15% of youth reported that their needs for professional mental health support have been unmet (Ministry of Health, 2022).

It is clear that psychologists are faced with a very high number of clients requesting assistance, along with an increase in clients with complex presenting problems (Te Pou o te Whakaaro Nui, 2018). This substantial service demand is further compounded by the fact that the mental health systems in both New Zealand and Australia have long been understaffed and underfunded (Mental Health Australia, 2023; Poole, 2023, June 30; Soit, 2023; Spence, 2022, July 28). There is a limited number of trained psychologists, facing very high client demand for their support. This issue is ubiquitous to the point that it has become common knowledge that the mental health systems in both New Zealand and Australia are under immense pressure. There is an essential need for more support for the psychology workforce and in turn the clients that they support (Australian Psychological Society, 2022, June 20; Department of Health and Aged Care, 2022; Spence, 2022, July 28). Both New Zealand and Australian Government inquiries have openly acknowledged this, describing the mental health systems as being at a crisis point (Soit, 2023; Spence, 2022, July 28), whereby they are not presently meeting the mental

health needs of the community (Department of Health and Aged Care, 2022; He Ara Oranga, 2018; Te Pou o te Whakaaro Nui, 2018).

Considering the high demand for psychological services across New Zealand and Australia, it is surprising that little attention has been given to the impact that this has on the current psychology workforce (He Ara Oranga, 2018; Te Pou o te Whakaaro Nui, 2018). Globally, psychologists have one of the most demanding roles (Dattilio, 2015). Psychologists are faced with many of the same stressors as other professions such as paperwork, long hours, and time constraints (Smith & Moss, 2009). However, they are also faced with additional occupation-specific stressors such as: exposure to sensitive and distressing content (Finlay-Jones et al., 2015; O'Connor et al., 2018); emotional isolation, unpredictability of work and client presentation (Finlay-Jones et al., 2015; Stafford-Brown & Pakenham, 2012); lack of client improvement; demanding caseloads, and managing ethical dilemmas (Barnett et al., 2007; Posluns & Gall, 2020; Stafford-Brown & Pakenham, 2012). It has been suggested that one particularly difficult stressor faced by psychologists is the need to balance adequate boundaries and emotional involvement with their clients, whilst maintaining an effective therapeutic alliance (Dattilio, 2015; Lizano, 2015). As such, irrespective of high service demands, managing the unique pressures and demands of being a psychologist poses a risk of experiencing significant stress (Barnett et al., 2007; Posluns & Gall, 2020; Stafford-Brown & Pakenham, 2012). If left unresolved, this stress can precipitate more serious issues such as compassion fatigue and burnout (Maslach, 2003; Posluns & Gall, 2020). Not surprisingly, clinicians and researchers alike express concern that psychologists in New Zealand and Australia are at heightened risk of burnout (Te Pou o te Whakaaro Nui, 2018).

Prevalence rates of burnout within helping practitioners (including psychologists) have been found to be between 21 – 69% (Johnson et al., 2018; Morse et al., 2012; Simpson et al., 2019). Burnout can lead to serious adverse outcomes for the psychologist, their clients and the psychology profession as a whole (Finlay-Jones et al., 2015). For the psychologist, burnout has been associated with a heightened

risk of anxiety, depression and substance misuse (Morse et al., 2012; Rupert et al., 2015; Smith & Moss, 2009). In terms of service delivery, greater burnout has been linked to impaired decision-making, (Johnson et al., 2018; McCormack et al., 2018), decreased attention, poor concentration (Johnson et al., 2018; Smith & Moss, 2009), and perhaps most concerningly, a reduced ability to empathise and build a strong therapeutic alliance with clients. Evidently, burnout impairs psychologists' ability to provide successful therapy (Di Benedetto & Swadling, 2014; McCormack et al., 2018; Smith & Moss, 2009). In addition, burnout is linked to absenteeism, high turnover, and decisions to leave the psychology profession, serving to only further perpetuate the already significant staff shortages within the mental health system (Te Pou o te Whakaaro Nui, 2018).

Considering the inherently high risk of burnout for psychologists, the current high demand for psychological services further increasing this risk, and the serious negative consequences of burnout, there is a clear need to protect New Zealand and Australian psychologists from burnout. Surprisingly, very little research has investigated burnout in psychologists (McCade et al., 2021; McCormack et al., 2018; Williams et al., 2020). Burnout research has predominately focused on health care professionals such as nurses (Dev et al., 2020; Dev et al., 2018; Lizano, 2015) and doctors (Alkema et al., 2008; Dev et al., 2020; Hashem & Zeinoun, 2020), rather than on mental health workers specifically (Johnson et al., 2018; Smith & Moss, 2009). The research that has specifically investigated mental health professionals has predominantly focussed on social workers (Lizano, 2015; O'Connor et al., 2018; Siebert, 2005) or psychiatrists (Kumar, 2007; Kumar et al., 2011). Burnout within psychologists specifically has been neglected, and the literature base is even more sparse within a New Zealand and Australian context (Simpson et al., 2019). This lack of attention is particularly concerning given that in order to effectively and competently support the growing population in need of mental health services within New Zealand and Australia, it is important to care for the most valuable resource in the pathway to mental wellbeing - the mental health workforce (Te Pou o te Whakaaro Nui, 2018).

In addition to the lack of research on burnout in psychologists, the burnout literature across helping professions has largely had a general focus on the incidence of burnout, its causes and associated negative consequences (Dorociak, Rupert, & Zahniser, 2017; Johnson et al., 2018; Lee & Miller, 2013). Limited research has focused on factors which may prevent, protect against, or decrease the prevalence of burnout (McCormack et al., 2018). Given that the wider burnout research indicates that it is easier to prevent or protect against burnout than it is to retroactively manage burnout, it is vital to explicitly examine factors that may buffer against stress, to provide psychologists with tools to enhance resilience and protect against burnout (Johnson et al., 2018; Maslach, 2003; Posluns & Gall, 2020; Smith & Moss, 2009).

It is also important that research addresses personal psychological resilience factors, as it is expected that there is no quick external fix for the systemic issues across the New Zealand and Australian mental health systems (Department of Health and Aged Care, 2022; He Ara Oranga, 2018). To illustrate, the Ministry of Health (2021) report acknowledged the imperative of improving mental health worker wellbeing, setting this as a medium-term goal for the workforce. However, this report did not discuss any specific plans or strategies for how to achieve this goal. This acknowledgement (yet lack of clear solutions) is reflective of the wider literature in which very little research examining burnout in psychologists worldwide has focused on protective or preventative factors (Kercher & Gossage, 2024; O'Connor et al., 2018; Simpson et al., 2019). Given the increasing pressure on the mental health workforce, the fact it is only expected to further increase for the foreseeable future (Te Pou o te Whakaaro Nui, 2018), and a lack of any immediately available solutions, there is a need to explore more individually controllable psychological factors which may protect against burnout.

Exploration of internal psychological resources of psychologists is important to support psychologists to effectively manage daily demands and ensure the longevity of the vital mental health workforce. One of the primary internal resources that is thought to be modifiable and buffer against

burnout is self-care (Di Benedetto & Swadling, 2014; Norcross & VandenBos, 2018; Rupert & Dorociak, 2019; Rupert & Kent, 2007). Self-care, however, has largely been assumed as self-explanatory within the literature with no attempt to define it beyond 'care for oneself', and limited research has thoroughly examined self-care in relation to psychologists and burnout. Further, there is limited information about factors that may also improve psychologists' engagement in self-care and in turn protect against burnout (Miller et al., 2019).

Consequently, this research investigates factors that may be protective or preventative against burnout in New Zealand and Australian psychologists. Specifically, it examines the assumed self-evident, yet scarcely researched, construct of self-care in relation to burnout. Further, this research examines self-compassion as an alternative protective factor and explores whether self-compassion may enhance, or moderate, psychologists' ability to engage in self-care. Prior to examining whether self-compassion may moderate self-care's impact on burnout in psychologists, the core constructs of self-compassion self-care, and burnout will be reviewed.

Chapter 2: Literature Review

What is Burnout?

The term burnout was originally used during the 1970's to describe the phenomenon of emotional and mental exhaustion, as well as decreased motivation and commitment seen among workers in the human service professions (Freudenberger, 1974; Maslach, 1976; Maslach & Pines, 1977). Research has flourished since this initial conception, with burnout since being recognised to be experienced across a range of professions and workers (Schaufeli, Bakker, et al., 2009). Burnout is now more commonly used to refer to the negative outcomes that gradually develop from the chronic exposure to work-related stressors (Maslach et al., 2001; Schaufeli, Bakker, et al., 2009). In the human services field, there is particular concern surrounding the impact of such negative consequences for the helping professional, as well as the vulnerable clients they intend to support (Johnson et al., 2018; Morse et al., 2012). Despite this substantial growth and interest in burnout there remains ambiguity and debate as to what specifically conceptualises burnout.

Burnout Syndrome and the Maslach Burnout Inventory (MBI)

The most prominent conceptualisation of burnout is the Maslach and Jackson (1981) *burnout syndrome*. According to this view, burnout is a multi-dimensional construct that encompasses three dimensions: emotional exhaustion, depersonalisation, and reduced personal accomplishment (Maslach & Jackson, 1981). Emotional exhaustion constitutes feelings of fatigue and depletion of both emotional and physical resources (Maslach et al., 2001). Depersonalisation involves workers developing pessimistic feelings and cynical attitudes towards their organisation, colleagues and/or clients (Maslach et al., 2001). Reduced personal accomplishment involves workers developing negative evaluations of themselves, feelings of incompetence and dissatisfaction with their workplace performance (Maslach et al., 2001). From Maslach and Jackson's perspective, these factors of the burnout syndrome develop as a

result of ongoing exposure to excessive interpersonal, social, and/or organisational stressors (Maslach et al., 2001; Schaufeli, 2003).

The Maslach Burnout Inventory (MBI; Maslach et al., 1997) was developed to measure these three dimensions of burnout. The MBI has been administered to such a large extent that it has become the 'gold standard', and the phenomenon that the MBI measures has become interchangeable with the very definition of burnout itself; "burnout is what the MBI measures!" (Schaufeli, 2003, p. 3). However, the MBI was developed through inductive factor-analysis of arbitrary items rather than solid clinical observation or robust theory (Maslach et al., 2001; Schaufeli, 2003). This limited theoretical foundation has resulted in concerns regarding the three dimensions of burnout.

Researchers have suggested that the three dimensions proposed to make up burnout are actually theoretically distinct and independent dimensions (Kristensen et al., 2005). Generally, there is agreement that emotional exhaustion is the central element of burnout (Schaufeli, Leiter, et al., 2009; Seidler et al., 2014). For example, research has found that utilising a single scale of the MBI, the emotional exhaustion subscale, can accurately be used in place of the entire MBI (Rohland et al., 2004). However, there is less consensus about the relevance of the two other dimensions of burnout (Shirom & Melamed, 2005). Specifically, depersonalisation can be viewed as a coping strategy that an individual may use in response to chronic stress (Kristensen et al., 2005; Lee & Ashforth, 1996; Schaufeli, 2003; Shirom, 1989) or alternatively as a precursor to developing emotional exhaustion by influencing lower personal accomplishment (Leiter, 1993; Schaufeli & Taris, 2005). Similarly, researchers have proposed that the dimension of reduced personal accomplishment could be considered an outcome of burnout (Kristensen et al., 2005; Lee & Ashforth, 1996; Schaufeli, 2003; Shirom, 1989) or rather an element of work engagement instead of burnout (Lee & Ashforth, 1996; Schaufeli, 2003). Collectively, these criticisms of the MBI suggest that emotional exhaustion is the central component of burnout, whereas

depersonalisation and personal accomplishment may be separate concepts related to burnout rather than aspects of burnout itself (Kristensen et al., 2005; Lee & Ashforth, 1996; Shirom & Melamed, 2005).

Copenhagen Burnout Inventory (CBI)

Responding to theoretical limitations of the MBI, Kristensen et al. (2005) developed an alternative model of burnout. This model of burnout builds on the literature that suggests emotional exhaustion is the core component or the 'heart' of burnout (Maslach et al., 2001; Shirom & Melamed, 2005; Siebert, 2005). This perspective on emotional exhaustion reflects the earlier conceptualisation of burnout, assuming it involves a combination of mental, emotional and physical exhaustion related to prolonged exposure to emotionally taxing circumstances (Pines & Aronson, 1988; Shirom, 1989). Kristensen et al. (2005) build upon this research by attributing fatigue and exhaustion to specific domains within one's life, such as work.

This attribution to specific areas of an individual's life is what distinguishes burnout from general fatigue (Kristensen et al., 2005). They propose burnout is made up of three types: personal, work-related and client-related burnout. Personal burnout is a measure of physical and psychological exhaustion that can be utilised regardless of an individual's occupational status. For example, with youth, retirees or the unemployed. The personal burnout element enables identification of exhaustion which individuals attribute to non-work factors such as health concerns or family stressors (Kristensen et al., 2005). Work-related burnout measures physical and psychological exhaustion that individuals attribute to work factors. Client-related burnout is a distinct work-related measure that refers to specific exhaustion that individuals attribute to their work with clients (e.g. patients, students).

Kristensen et al. (2005) developed the Copenhagen Burnout Inventory (CBI) to measure burnout in line with this conceptualisation. The CBI consists of three scales, representing each type of burnout, that can be used as independent scores (Kristensen et al., 2005) or combined for a total burnout score (Di Benedetto & Swadling, 2014; McCade et al., 2021; Milfont et al., 2008). The CBI is a valid measure of

burnout that has good predictive validity as well as concurrent validity (Kristensen et al., 2005).

Consequently, the CBI was chosen for this current study to measure burnout; it is important to utilise valid measures of burnout, to help combat the oversaturation and reliance on MBI.

Distinction from Compassion Fatigue

Given the conceptual ambiguity of burnout, it is important to distinguish it from similar constructs such as compassion fatigue (CF). Within the literature, the term CF is sometimes used interchangeably with burnout. However, CF represents a distinct concept (Newell & MacNeil, 2010; Sinclair et al., 2017; Van Mol et al., 2015). CF is similar to burnout in that both relate to negative emotional states that result from factors associated with an individual's work environment (Alkema et al., 2008). However, CF relates to the exhaustion, both emotional and physical, that occurs in caring professionals due to the chronic use of empathy and ongoing exposure to the suffering of others (Figley, 2002; Sinclair et al., 2017; Van Mol et al., 2015). CF can be thought of as the 'the cost of caring' (Figley, 1995). Similar to burnout, this exhaustion can lead to a reduction in capacity to be compassionate and empathic, or a desensitization, towards one's client(s).

The core distinction between CF and burnout is the source of the exhaustion (Van Mol et al., 2015). CF occurs directly as a result of secondary exposure to client's distress and ongoing demands to be empathetic and compassionate towards others suffering (Alkema et al., 2008). In contrast, burnout can be the result of other stressors, such as workload demands or time pressures, and is not exclusive to the demands associated with being caring and compassionate to clients (Maslach et al., 2001). In summary, burnout can be seen as a more general, all-encompassing phenomenon in response to chronic work-related stress, whereas CF is exhaustion specifically related to caring factors (Alkema et al., 2008). Burnout takes into consideration wider ecological and holistic impacts on psychologists, including things such as relevant community and global events (for example Covid-19). Consequently, examining burnout

rather than CF enabled this research to look at psychologists overall functioning not just in relation to their work with clients, but also other factors that could potentially affect their client work.

Prevalence of Burnout

Limited research has investigated burnout in psychologists, especially within a New Zealand or Australian context psychologists (Di Benedetto & Swadling, 2014; McCade et al., 2021; Williams et al., 2020). In fact, research on the psychology workforce in New Zealand is generally lacking (Kennedy et al., 2022). Two of the main studies to sample New Zealand psychologists specifically, focus primarily on the experiences of compassion fatigue (Kercher & Gossage, 2024; McCormick, 2014). Although not explicitly focusing on burnout, both studies include findings on burnout prevalence, within the context of compassion fatigue, within New Zealand psychologists.

A study by McCormick (2014) which investigated resilience and wellbeing among a sample of 224 New Zealand psychologists reported relatively low compassion fatigue and high compassion satisfaction. They found that maladaptive coping strategies and occupational stressors were associated with lower professional quality of life (including burnout), while higher professional quality of life was linked to several positive factors including self-care and engagement in personal therapy. A more recent study by Kercher and Gossage (2024) focused on the impact of Covid-19 on compassion fatigue among New Zealand psychologists. They found that since the pandemic, rates of psychological distress, including burnout, have increased among New Zealand psychologists. The mean burnout rate as measured by the Professional Quality of Life Scale for the 149 participants in the sample was 24.83 indicating a mild risk of burnout for New Zealand psychologists. Kercher and Gossage (2024) directly compared this burnout level with that of McCormick (2014) and found that burnout within New Zealand psychologists was markedly and significantly higher than the pre-covid rate of 20.78. Thus, indicating that burnout rates appear to be worsening within New Zealand psychologists.

One of the only burnout specific studies to include New Zealand participants is a South Australian study which investigated the role of maladaptive schema and coping on the incidence of burnout in registered psychologists around the world. Simpson et al. (2019) found that 18.3% of psychologists were considered to have high levels of emotional exhaustion and that early maladaptive schemas as well as maladaptive coping strategies were significantly associated with heightened emotional exhaustion. Although this study included New Zealand participants, the results in reference to country of residence were not delineated. The research base within psychologists in Australia is slightly larger than within New Zealand; nonetheless, compared to other helping professionals, the research base for psychologists is still surprisingly limited and in need of further exploration (Simpson et al., 2019).

Di Benedetto and Swadling (2014) explored burnout within an Australian context and found that 14.4% of Australian psychologists met the threshold for overall burnout, with the greatest prevalence seen for personal burnout at 35.3%. An earlier study investigating burnout within Australian clinical psychologists found 8% met the criteria for burnout (D'Souza et al., 2011). In a study of 260 psychologists, Bearse et al. (2013) found that burnout was identified as their most common stressor. A more recent study investigating psychologist burnout in Australia found that nearly 30% of respondents met the criteria for burnout (McCade et al., 2021). Further, a recent systematic review of 40 studies investigating burnout within psychotherapists reported moderate-high burnout in over 54.54% of therapists, with 22.83% meeting the criteria for moderate/moderate-high burnout using the CBI (Simpson et al., 2019).

Thus, the available literature estimates prevalence rates for burnout (in particular emotional exhaustion) among psychologists to range between 27% to 59% (McCormack et al., 2018; Rupert & Kent, 2007; Rupert & Morgan, 2005; Williams et al., 2020). However, given the limited research on burnout within psychologists specifically, it is unclear how accurate these estimates may be. When

looking at burnout in mental health professionals generally, prevalence rates have been found to range between 21 – 69% (Johnson et al., 2018; Morse et al., 2012; Simpson et al., 2019). This indicates that burnout is a significant risk for mental health professionals, including psychologists. The relative paucity of literature is particularly concerning given the impacts and consequences that burnout can have for the psychologist, their clients and the Psychology profession as a whole (Finlay-Jones et al., 2015).

Burnout Consequences

Burnout can cause serious adverse mental and physical consequences for psychologists (Finlay-Jones et al., 2015; Simpson et al., 2019). Psychologists experiencing burnout are at risk of overall poor quality of life, fatigue, social withdrawal and insomnia (McCormack et al., 2018; Salvagioni et al., 2017; Yang & Hayes, 2020). They are also at heightened risk for physical consequences such as headaches, muscular pain and increased risk of cardiovascular disease and diabetes (Salvagioni et al., 2017). Further, psychologists are at heightened risk of anxiety, depression, substance misuse and suicidality (Morse et al., 2012; Rupert et al., 2015; Smith & Moss, 2009). Two studies investigating depression in psychologists found that over 60% of psychologists had been depressed at least once during their careers (Gilroy et al., 2002; Pope & Tabachnick, 1994). Concerningly, Gilroy et al. (2002) found 42% of respondents had struggled with suicidal thoughts or actions at some point.

Crucially, burnout also has acute negative consequences for clients (Finlay-Jones et al., 2015). Greater levels of burnout in psychologists have frequently been linked to impaired decision-making skills (Johnson et al., 2018; McCormack et al., 2018) as well as decreased attention and concentration (Johnson et al., 2018; Smith & Moss, 2009) which can impact therapeutic effectiveness and client outcomes (Bearse et al., 2013; Morse et al., 2012; Posluns & Gall, 2020). The impact of burnout and its associated personal consequences can result in diminished motivation and empathic ability (Norcross & VandenBos, 2018) and lead to psychologists working at reduced capacity (Rupert & Morgan, 2005) which can potentially have harmful outcomes for the client. A study by Rupert and Kent (2007) found

burnout in psychologists was positively associated with overinvolvement with clients, indicating burnout may result in difficulty maintaining appropriate boundaries within the therapeutic relationship. Significantly, burnout can result in impaired professional competence and negatively impact psychologists' ability to build a strong therapeutic alliance with their clients (Di Benedetto & Swadling, 2014; Hashem & Zeinoun, 2020; McCormack et al., 2018; Norcross & VandenBos, 2018; Smith & Moss, 2009), a core component of successful therapy. Overall, these impacts can diminish the quality of services and lead to suboptimal care being provided to clients (McCormack et al., 2018; Morse et al., 2012; Posluns & Gall, 2020).

Finally, burnout can have negative consequences for the psychology profession as a whole (Finlay-Jones et al., 2015). This is due to the potential for burnout to result in reduced productivity and commitment to the organisation (Morse et al., 2012), increased staff turnover (Williams et al., 2020) and higher levels of absenteeism (Simpson et al., 2019). All of these factors may lead to costs for the organisation and further limit resources available (Dreison et al., 2018) within the psychology workforce. Higher levels of emotional exhaustion in particular have been linked to increased absenteeism (Johnson et al., 2018) and turnover intention in mental health workers (Acker, 2012; Johnson et al., 2018). Absenteeism and turnover result in both financial and resource costs for organisations due to the impact of lost productivity along with the expense associated with recruiting and training replacement staff (Acker, 2012; Johnson et al., 2018). Additionally, burnout places further burden on the psychology workforce and the mental health systems in New Zealand and Australia, which are already under pressure due to a shortage of psychologists who cannot meet the increasing demand for care (Australian Psychological Society, 2022, June 20; Department of Health and Aged Care, 2022; Ministry of Health, 2021; Spence, 2022, May 19). Given this risk of burnout along with the serious negative consequences, it is important to investigate factors that could ameliorate or protect against burnout in psychologists.

Causes of Burnout

Job Demands-Resources (JD-R) & Conservation of Resources (COR) Theory

Burnout is understood to have a gradual onset and is argued to occur insidiously in response to ongoing exposure to occupational stressors that have not been successfully managed (Maslach et al., 2001; McCormack et al., 2018; Sinclair et al., 2017). Two significant factors associated with burnout are demands and resources. Within burnout research, two key models that offer a conceptual understanding of burnout are the Job Demands-Resources (JD-R; Demerouti et al., 2001) model and the Conservation of Resources (COR; Hobfoll, 1989; Hobfoll et al., 2018) theory. JD-R combined with COR provides a more comprehensive understanding of occupational stress and burnout (Bakker, Demerouti, et al., 2023).

The JD-R model states that burnout is the result of an imbalance between persistent work demands and an individual's perceived available resources to buffer these demands (Bakker, Demerouti, et al., 2023; Buonomo et al., 2022; Demerouti et al., 2001; Schaufeli, Bakker, et al., 2009). Job demands comprise the psychological, social, physical, or organisational aspects of a role that involve sustained effort and result in physiological and/or psychological costs (Bakker, Demerouti, et al., 2023; Demerouti et al., 2001). Contrastingly, job resources are the psychological, social, physical, or organisational components of a role that can be motivating, lead to personal growth and offset the impact of job demands (Bakker & Demerouti, 2017; Bakker, Demerouti, et al., 2023; Buonomo et al., 2022). Individuals need to utilise a variety of resources to enable them to cope with environmental stressors (i.e. work demands; Bakker & Demerouti, 2017). JD-R theory proposes that it is these resources that help reduce the effect of job demands and mitigate the risk of burnout (Bakker, Demerouti, et al., 2023). In this way, burnout is the consequence of unresolved exposure to recurrent work stressors without adequate compensatory resources (Maslach et al., 2001; McCormack et al., 2018; Rupert et al., 2015).

Complementary to JD-R, COR theory focuses on individuals' acquisition and loss of protective resources. COR theory is a more broad theory of stress commonly utilised within coping research; however, it also has relevance for understanding and explaining how burnout may occur in individuals (Bakker, Xanthopoulou, et al., 2023; Buonomo et al., 2022; Hobfoll et al., 2018). According to COR theory, an individual's resources influence the impact of stressors (Hobfoll, 1989; Hobfoll et al., 2018). Thus, resources play a key role in the development of burnout (McCormack et al., 2018; Rupert et al., 2015). Specifically, the theory proposes that successful acquisition of resources can result in positive wellbeing; while potential or actual resource loss due to environmental stressors can result in psychological stress (Hobfoll, 1989). Hobfoll (1989) proposes that individuals therefore aim to maximise resource gains (in order to buffer any future losses) and minimise any resource losses to protect against the onset of psychological stress. In this way, individuals are able to cope with various environmental stressors through the use of their available personal resources. Ongoing exposure to resource depleting environments can be especially harmful and can result in a net loss of individual resources available to buffer environmental stressors, which can increase the risk of chronic stress conditions such as burnout (Hobfoll, 1989; Hobfoll et al., 2018).

Various demands and resources are highlighted as important risk factors for the onset of work-related stress and development of burnout (Bakker, Xanthopoulou, et al., 2023; Hobfoll et al., 2018). Resources, in particular, are important as the extent and severity of stress can be argued to be relative to an individual's actual or perceived availability of resources at a particular time (Bon & Shire, 2022). Adopting a theoretical framework from JD-R and COR focuses on the importance of psychologists' resources to effectively manage the demands of their job.

Risk Factors: Demands & Resources

Throughout the literature, research into demands and resources linked with burnout has often been categorised broadly into either internal (personal) factors or external (occupational) factors

(Bakker, Demerouti, et al., 2023; Buonomo et al., 2022; Kumareswaran, 2023; McCormack et al., 2018). Resources are particularly important as they can help individuals manage occupational demands and buffer the impact of stress (Bon & Shire, 2022; McCormack et al., 2018; Rupert et al., 2015). General research on risk factors associated with one's occupational environment that can lead to burnout has focused on both occupational demands and limited work resources such as: work overload or underload (Beheshtifar & Omidvar, 2013; Yang & Hayes, 2020), a lack of collegial or managerial support (Beheshtifar & Omidvar, 2013), job insecurity (Beheshtifar & Omidvar, 2013), role conflict and/or ambiguity, work setting (Sim et al., 2016), a lack of control and/or autonomy, as well as limited decision-making ability and few opportunities for promotion (Beheshtifar & Omidvar, 2013; Kumareswaran, 2023). General research into personal risk factors has focused on factors which can influence an individual's ability to manage work demands and cope with environmental stressors (Kumareswaran, 2023). These include personality traits (e.g. perfectionism, neuroticism), individual coping style, self-efficacy and emotional intelligence, as well as demographic factors such as age, gender, ethnicity, marital status (Beheshtifar & Omidvar, 2013; George-Levi et al., 2022; Rupert et al., 2015; Yang & Hayes, 2020).

Of these more general risk factors, factors that have received the most attention for psychologists have been workload and task division (McCormack et al., 2018; Rupert & Kent, 2007; Rupert et al., 2009; Yang & Hayes, 2020), client type, and work setting (Rupert & Morgan, 2005). Specifically, research on psychologists has consistently linked a greater number of hours worked to an increased risk of burnout, especially emotional exhaustion (Rupert et al., 2015; Rupert & Morgan, 2005). However, research has found that it is not only the workload (total hours) that is important in the development of burnout for psychologists, but more specifically how those hours are spent. For example, time spent in particular work activities has also been linked to burnout (Rupert et al., 2015) with more hours spent completing paperwork or administrative tasks linked with an increased risk of

emotional exhaustion in psychologists (Ackerley et al., 1988; Rupert et al., 2009). Contrastingly, more hours spent in psychotherapy or with clients has not been linked to higher levels of burnout within psychologists (McCormack et al., 2018; Rupert & Kent, 2007; Rupert & Morgan, 2005).

One exception to client hours not being associated with greater burnout is with regards to impacts that are related to the type of client seen (Rupert et al., 2015; Sim et al., 2016). Specifically, Ballenger-Browning et al. (2011) found psychologists who saw more clients with personality disorders to be at a greater risk of burnout, specifically depersonalization. Other studies have found that working with clients who display negative behaviours (such as client aggression, suicidality, and psychotic behaviour) has also been associated with a greater risk of emotional exhaustion in psychologists (Ackerley et al., 1988; Rupert & Kent, 2007; Rupert & Morgan, 2005). The impact of client presentation on burnout risk may be due to the additional time or emotional investment required by psychologists and stress associated with managing higher levels of risk (Rupert et al., 2015).

Prior research has linked work setting with the onset of burnout in mental health professionals including psychologists (Ackerley et al., 1988; Rupert & Morgan, 2005). The reason for this finding however is unclear; some researchers have argued that differences within work settings such as hours worked, types of clients, level of control and autonomy may account for, at least partially, the variation in burnout seen (Rupert & Morgan, 2005). For example, Rupert and Morgan (2005) found psychologists working in private practice had a lower risk for burnout than those working in agency settings. However, they also found variations within settings regarding other work-related factors are linked with burnout. Specifically, they found that private practice psychologists were afforded more agency and control over their work, worked less hours per week and spent less time engaged in other organisational tasks such as paperwork than agency psychologists (Rupert & Morgan, 2005). These findings were similar to earlier research by Ackerley et al. (1988). In addition, Rupert and Morgan (2005) found that agency psychologists also reported greater exposure to negative client behaviours than private practice

psychologists. Consequently, these differences across workplace settings may be better explained and accounted for by workplace factors such as hours worked, level of autonomy or job control, administrative tasks and frequency of exposure to negative client behaviours (Rupert & Morgan, 2005).

Contrastingly, research on burnout within Australian psychologists found no difference between occupational setting and burnout (Di Benedetto & Swadling, 2014). The lack of a significant finding could be the result of cultural and contextual differences between Australia and America, in particular the difference in health care systems between the two countries and thus occupational tasks associated with various work settings (Di Benedetto & Swadling, 2014). For example, within Australia, private practice psychologists are integrated within the public mental health system which may have resulted in a difference in work setting findings between Australia and America (Di Benedetto & Swadling, 2014).

On top of these more general factors, psychologists often experience further unique demands and can exhibit certain personal factors that increase the risk of burnout within this occupation (Gardner & O'Driscoll, 2007; O'Connor et al., 2018; Simpson et al., 2019). Psychologists frequently put the needs of others ahead of their own (Norcross & VandenBos, 2018) and often have heightened sensitivity to those around them and their environment (O'Connor et al., 2018). The altruistic nature of psychologists combined with the sensitivity required for their roles, leaves them at risk of 'running on empty' in that their resources are depleted in response to managing demands, leading to them becoming emotionally drained.

Additionally, psychologists are regularly exposed to sensitive and often distressing client content (Finlay-Jones et al., 2015; O'Connor et al., 2018) and they are expected to continually empathise with and hold space for clients suffering (Finlay-Jones et al., 2015) without receiving anything emotionally in return (O'Connor et al., 2018). They are faced with delicately balancing appropriate boundaries and emotional involvement with their clients, whilst maintaining an effective therapeutic alliance (Dattilio, 2015; Lizano, 2015; Maslach, 2003). Over time, this way of relating can take an emotional toll on the

therapist and contribute to an increased risk of emotional exhaustion (Dattilio, 2015; Maslach, 2003; Norcross & VandenBos, 2018).

Psychologists can also experience professional and emotional isolation due to the confidential nature of their roles (O'Connor et al., 2018); they commonly have to juggle demanding caseloads alongside managing ethical dilemmas (Barnett et al., 2007; Posluns & Gall, 2020; Smith & Moss, 2009; Stafford-Brown & Pakenham, 2012). Further risk factors for burnout are associated with the ambiguity of work and client presentation (Finlay-Jones et al., 2015; Stafford-Brown & Pakenham, 2012) as well as lack of client improvement that psychologists are sometimes faced with and potential blame for such lack of improvement (Barnett et al., 2007; Norcross & VandenBos, 2018; Posluns & Gall, 2020; Smith & Moss, 2009; Stafford-Brown & Pakenham, 2012). Consequently, these additional demands faced by psychologists increases their vulnerability to heightened job-stress (Dattilio, 2015; Maslach, 2003; Norcross & VandenBos, 2018). If left unresolved, stress can precipitate more serious issues such as professional impairment and burnout (Maslach, 2003; Posluns & Gall, 2020).

Compared to research on occupational risk factors, the literature base investigating the impact and importance of personal characteristics is relatively limited (Di Benedetto & Swadling, 2014; Dorociak, Rupert, & Zahniser, 2017; Simionato & Simpson, 2018). This is particularly the case for burnout in psychologists where research on personal factors is often limited to demographics such as age (Rupert et al., 2015; Siebert, 2005) with few studies extending further to investigate personal resources such as coping style or self-efficacy (Siebert, 2005; Yang & Hayes, 2020). Further, research investigating potential ways to reduce the risk of burnout among psychologists has primarily focused on adjustment of the external work environment to reduce the negative features of burnout rather than enhancing personal protective factors of the psychologist (Schaufeli, Bakker, et al., 2009). For example, increased salary, opportunity for promotion, and improved co-worker and supervisor support have been focused on as solutions to mitigate burnout (Schaufeli, Bakker, et al., 2009) more so than focusing on the

promotion of wellness-enhancing protective factors such as mindfulness, self-care or coping (Siebert, 2005; Yang & Hayes, 2020). This is despite research indicating that personal factors are just as important as occupational factors when it comes to mitigating stress and consequently burnout (Maslach & Leiter, 2007; Maslach et al., 2001; Rupert et al., 2015).

Organisational factors have been found to only partially explain burnout in psychologists; interventions that have ignored personal factors (and exclusively attempted to change occupational factors) to mitigate burnout have been ineffective, compared to interventions that have included personal factors (Simpson et al., 2019). A recent study by Simpson et al. (2019), one of the only studies to investigate the impact of coping mode on the development of burnout in psychologists, found that coping explained a further 6% of the variance in burnout on top of that explained by occupational factors and demographics.

It is clear that burnout is a serious occupational hazard, and psychologists face increased risk due to the unique pressures and features of their roles. Burnout results in serious negative consequences for the psychologist, their client(s), and the psychology professional and as such it is important to investigate factors that may mitigate the risk of burnout within psychologists. Given the current context in New Zealand and Australia with increased demands and pressures on psychologists due to heightened service demand and lack of funding, it is not a quick fix to reduce or remove demands. Consequently, it is especially important to focus on factors that can help buffer these demands that may be more easily modifiable.

Two core personal protective factors that have been linked with burnout (that are more easily modifiable) are self-care and self-compassion. To date no known studies have investigated self-care or self-compassion as important personal factors in relation to burnout within New Zealand and Australian psychologists. The lack of consideration of self-care is surprising given the common agreement that self-care buffers against stress (Di Benedetto & Swadling, 2014; Posluns & Gall, 2020; Stevanovic & Rupert,

2004) and that self-care is a vital activity, if not ethical imperative, for practising psychologists (Norcross & VandenBos, 2018; The New Zealand Psychological Society, 2002).

Defining Self-Care

Self-care has gained increasing popularity over the last decade, particularly within helping professionals, as it has frequently been proposed to be a key mechanism for buffering against and alleviating distress (El-Ghoroury et al., 2012). Self-care offers a means for not only protecting against negative outcomes, such as burnout, but also as a tool for proactively enhancing positive outcomes such as one's health and wellbeing (Colman et al., 2016; Dorociak, Rupert, & Zahniser, 2017; Lee & Miller, 2013; Lee et al., 2020; Wise & Barnett, 2016; Wise et al., 2012). Despite this research, defining self-care is difficult, as across the literature there is limited agreement among researchers as to what self-care actually is (Dattilio, 2015; Lee & Miller, 2013; Norcross & VandenBos, 2018; Rupert & Dorociak, 2019). Throughout the literature, self-care has been described in various ways including as an ability (Collins, 2005), a process (Baker, 2003), a set of principles to follow (Norcross & VandenBos, 2018) or strategies to utilise (Mahoney, 1997). A number of researchers fail to even provide a clear definition of self-care in their research, perhaps assuming that the understanding of self-care is implied by the term itself (i.e., self-care refers to caring for oneself; Lee & Miller, 2013).

A major part of the challenge in defining self-care lies in the question of what constitutes a self-care behaviour or activity, as self-care can be subjective and take various forms (Rupert & Dorociak, 2019). Self-care can include a broad number of activities across different areas of life, and the chosen activities often vary depending on idiosyncrasies of the individual (Rupert & Dorociak, 2019). As such, some researchers argue that what constitutes self-care is more about purposeful engagement with behaviours or activities rather than any specific behaviour itself. In this way, effective self-care activities are those that an individual finds useful rather than a set of behaviours that are universal for everyone.

An individual can engage in a number of self-care activities or behaviours including exercise, engaging in hobbies, healthy eating and sleeping, meditation and building a social support network (Colman et al., 2016; Rupert & Dorociak, 2019; Sanchez-Reilly et al., 2013). It is the active engagement in these activities that distinguishes self-care from other health behaviours (Colman et al., 2016). For example, having a gym membership itself would not represent self-care; however, setting aside time to travel to and workout at the gym would be classified as engagement in self-care.

Further, the utility of self-care behaviours is inherently subjective, with the chosen activities often varying depending on idiosyncrasies of the individual and their circumstances (Rupert & Dorociak, 2019). For example, while one individual may find engaging in social gatherings a means of improving their subjective wellbeing, another individual may find such activities result in the opposite. Some individuals may find attending the gym regularly enhances their sense of wellbeing, while for others' activities such as going for nature walks or engaging in yoga practices may be what fills their cup.

Given the subjective nature of self-care and the fact that what constitutes self-care can incorporate various activities across numerous areas (Rupert & Dorociak, 2019), operationalising self-care for research is difficult (Callan et al., 2021; Coleman et al., 2016; Dorociak, Rupert, Bryant, et al., 2017). Researchers have attempted to operationalise self-care by offering more specificity around self-care behaviours by breaking them down into specific domains. Common domains include psychological, physical, social, and/or spiritual aspects of self-care (Baker, 2003; Butler et al., 2019). This view of self-care relates to Aotearoa New Zealand's Māori model of health, Te Whare Tapa Wha (Durie, 1998), which highlights the importance of four pillars of Māori health (physical, spiritual, family and mental health). Research on self-care often includes a collection of these dimensions (Lee & Miller, 2013).

More recently, other authors have argued that for self-care to be accurately represented, researchers need to consider an additional domain; professional self-care (Dorociak, Rupert, & Zahniser, 2017; Lee & Miller, 2013). These researchers argue that self-care is important for both the individual self

as well as the professional self and that self-care in the professional sense is largely neglected throughout the literature (Dorociak, Rupert, & Zahniser, 2017; Lee & Miller, 2013). Lee and Miller (2013) argue that unique attention needs to be paid to self-care practices in relation to one's work. This is especially the case for helping professionals who have both unique demands, as well as unique influences of self-care on delivery of services. Despite these variances, central to all conceptualisations is the idea that self-care involves an individual's deliberate engagement in a multitude of different behaviours with the aim of enhancing holistic wellbeing (Coleman et al., 2016; Miller et al., 2019).

For the purposes of this research, Lee and Miller (2013) conceptualisation of self-care, which incorporates self-care behaviours under the distinct domains of personal and professional self-care, will be used. Their definition of self-care highlights the reciprocal nature of personal and professional self-care for helping professionals. This perspective acknowledges that personal affairs can influence an individual's professional role just as work-related circumstances can affect one's personal life. Lee and Miller (2013) describe personal self-care as the deliberate engagement in activities that improve overall health and wellbeing of the individual, outside the workplace. Professional self-care refers to engagement in activities that enhance the overall wellbeing and effectiveness of the individual within their occupational role (Lee & Miller, 2013; Lee et al., 2020).

Within their definition, they recognise that for self-care to be effective it needs to extend to both the individual self as well as the professional self. They also acknowledge that the personal and professional self are not mutually exclusive but that they are two distinct (yet complementary) areas of self-care that need to be considered together to attain a comprehensive understanding of self-care (Lee & Miller, 2013; Miller et al., 2018; Skovholt et al., 2001). For example, the personal self-care behaviour of getting enough sleep each night influences an individual's cognitive functioning both in their personal life and within their work context. Considering both personal and professional self-care is important for facilitating appropriate work-life balance (Rupert & Kent, 2007; Stevanovic & Rupert, 2004).

Consequently, when investigating self-care within mental health professionals such as psychologists, it is crucial to consider self-care within both the personal and professional environment.

Benefits of Self-Care

Although there are challenges with operationalising self-care, throughout the literature effective self-care engagement has been linked to improved overall wellbeing (Colman et al., 2016; Richard & Shea, 2011; Rupert & Kent, 2007), lower negative affect and higher positive affect (Zahniser et al., 2017), improved coping and resilience (Newell & MacNeil, 2010; Richard & Shea, 2011; Stevanovic & Rupert, 2004), increased quality of life (Colman et al., 2016; Richard & Shea, 2011), enhanced occupational functioning and clinical competence (Norcross & VandenBos, 2018; Wise & Reuman, 2019), increased quality of care within helping professions (Barnett et al., 2005), as well as decreased stress levels (Colman et al., 2016; Rupert & Kent, 2007; Stevanovic & Rupert, 2004) and a diminished risk of deleterious outcomes such as burnout (Posluns & Gall, 2020; Stevanovic & Rupert, 2004).

Conversely, a lack of self-care or ineffective self-care has been linked to increased stress levels (Posluns & Gall, 2020), a heightened risk of depression, burnout and compassion fatigue (Alkema et al., 2008; Barnett et al., 2007), as well as a decline in overall health status including higher incidences of cardio vascular disease and substance use (Lizano, 2015; Morse et al., 2012). For psychologists in particular, poor self-care has been associated with greater emotional depletion and exhaustion (Collins, 2005), decreased competency (Wise et al., 2012; Wise & Reuman, 2019), as well as impaired quality of care for clients (Barnett et al., 2007). In this way, self-care is an important tool for not only buffering the negative consequences of burnout but also for promoting wellbeing (Barnett et al., 2007; Posluns & Gall, 2020; Rupert & Dorociak, 2019).

Importance of Self-Care for Psychologists

The value of self-care is even more salient for psychologists given its utility in buffering the inherent stress associated with psychological work (Rupert & Dorociak, 2019) and the impact that

heightened stress can have on the therapeutic alliance and client outcomes (Norcross & VandenBos, 2018; Posluns & Gall, 2020). Effective engagement in self-care is arguably critical for the individual practitioner's wellbeing as well as for maintaining competence and optimal psychological practice (Barnett et al., 2007; Norcross & VandenBos, 2018; Wise & Reuman, 2019). The wellbeing and competence of the clinician could be considered to be part of their individual responsibility to their clients (Coleman et al., 2016). Psychologists who fail to consider their own needs and take steps to maintain their own wellbeing, are at risk of being unable provide necessary services or care to clients (Bamonti et al., 2014; Barnett et al., 2005; Miller et al., 2018). Consequently, the psychology profession has recognised the necessity of self-care for both the clinician and their clients (Callan et al., 2021; Posluns & Gall, 2020). It is not surprising then, that for ethical and clinical reasons, self-care is increasingly viewed as an imperative for psychologists (Barnett et al., 2007; Barnett et al., 2005; Norcross & VandenBos, 2018; Wise et al., 2012; Wise & Reuman, 2019).

This imperative is advocated for in ethical codes of practice (Barnett et al., 2005; Norcross & VandenBos, 2018; Wise et al., 2012; Wise & Reuman, 2019). For example, the APS Code of Ethics and the New Zealand Code of Ethics for Psychologists both refer to competence as a core principle necessary for psychologists to engage in responsible caring and ethical practice (Australian Psychological Society, 2007; Dattilio, 2015; The New Zealand Psychological Society, 2002; Wise et al., 2012). More specifically, both codes highlight the importance of psychologists being aware of and taking steps to ensure they avoid impairment and maintain their ability to provide safe, effective psychological service to their clients (Australian Psychological Society, 2007; The New Zealand Psychological Society, 2002). Further, the codes reference psychologists' obligation to ensure their own experiences, attitudes, stresses as well as their physical and mental health do not impact their work with clients (Australian Psychological Society, 2007; The New Zealand Psychological Society, 2002). Although not explicitly referring to self-care, self-care practices are commonly referenced to be the primary professional development action to

meet these principles and prevent negative outcomes (Bamonti et al., 2014; Wise et al., 2012; Wise & Reuman, 2019).

Thus, the competent practice of psychologists' hinges on them caring for their own wellbeing and ensuring they take proactive steps to avoid impairment (Posluns & Gall, 2020). Without attending to their own needs first and ensuring their own wellbeing, psychologists are not able to provide effective care or prevent harm to their clients (Callan et al., 2021; Norcross & VandenBos, 2018; Wise et al., 2012). In this way, self-care is a core preventative practice that all psychologists need to engage in on an ongoing basis to ensure their optimal functioning both professionally and personally (Barnett et al., 2005; Posluns & Gall, 2020; Rupert et al., 2015; Wise & Barnett, 2016; Wise et al., 2012).

Psychologists' Engagement in Self-Care

Despite the importance of self-care, and even their ethical imperative for engaging in it, helping professionals have been found to be poor at looking after their own needs (Norcross & VandenBos, 2018). Miller et al. (2019) found that American social workers engaged only moderately in both profession and personal self-care. A similar study investigating self-care in Polish social workers also found only moderate engagement in self-care practices (Miller et al., 2021). A review by Dattilio (2015) found that across the literature, mental health professionals tend to have chronic neglect for their own wellbeing. The very nature of psychologists' roles and psychologists' natural tendency to attend first and foremost to the emotions and needs of others, places them at heightened risk for neglecting their own emotional state and requirements in favour of others (Barnett et al., 2007; Dattilio, 2015; Posluns & Gall, 2020).

The current literature base indicates that despite mental health professionals spending the majority of their career promoting wellness and equipping clients with tools for effective self-care, they often do not follow their same advice (Coleman et al., 2016; Dattilio, 2015). This likelihood for neglect is particularly concerning given the importance of self-care not only for psychologists' wellbeing but for

ensuring competent psychological practice (Barnett et al., 2007; Barnett et al., 2005; Wise & Barnett, 2016; Wise et al., 2012; Wise & Reuman, 2019). By neglecting their own self-care needs, psychologists ironically run the risk of harming the very people they place above their own needs - their clients. It has long been known within helping professions that care of self and care of others are not independent; rather, to ensure optimal functioning and reduce the risk of negative stress outcomes it is crucial for psychologists to maintain a sustainable balance between caring for clients and looking after themselves (Wise et al., 2012).

Psychologists are just as at risk, if not more so than most, to the impacts of life's stressors and pressures given the nature of their daily lives (Dattilio, 2015). Given the tendency to place others above themselves, psychologists can be poor at recognising signs of distress or their own needs and may even have blind spots when it comes to focusing on their own wellbeing (Barnett et al., 2007). Further, even when they do recognise signs of stress, psychologists may ignore or minimise their importance so as to not appear vulnerable or incompetent in fulfilling their roles (Barnett et al., 2007). However, this lack of action in the face of stress is the very thing that can result in stress progressing to burnout and professional impairment (Barnett et al., 2007). Concerningly, prior research found that nearly 60% of psychologists admitted to working when impaired and unable to provide effective quality of care (Pope et al., 1987). A further study similarly found that 59% of American psychologists admitted not seeking psychological treatment despite knowledge that they needed help (Bearse et al., 2013).

Given the substantial risks associated with neglecting self-care, alongside psychologists' knowledge of self-care's value, it is perplexing that psychologists are often reluctant when it comes to addressing their own needs (Coleman et al., 2016). The research base suggests that mental health professionals have similar reasons for avoiding treatment and acknowledging when they may need help as the rest of society, including their clients (Dattilio, 2015). Specific obstacles to help-seeking and self-care for psychologists include social stigma, reluctance for self-disclosure, difficulties with anonymity in

the profession, concern of consequences of admitting they may be struggling as well as fear of being deemed impaired (Bearse et al., 2013; Dattilio, 2015; Norcross & VandenBos, 2018).

A large barrier towards psychologists' engagement in self-care surrounds the notion that helping professionals may see themselves as less deserving of self-care than their clients (Coleman et al., 2016). The general nature and the day-to-day work life of psychologists leads to a natural tendency to extend care to others rather than towards themselves even when they may need it most (Coleman et al., 2016). Further, it can be difficult for psychologists to find psychological support within their community and be able to maintain privacy (Bearse et al., 2013; Norcross & VandenBos, 2018). These risks associated with neglecting self-care, along with psychologists' chronic disregard for their own wellbeing (Dattilio, 2015), highlights the importance of exploring factors that could promote psychologists' effective engagement in self-care practices and decrease the risk of burnout.

What is Self-Compassion?

One such factor that has gained considerable attention recently is self-compassion. Self-compassion has been independently linked to stress and burnout (Barnard & Curry, 2012; Finlay-Jones et al., 2015; Hashem & Zeinoun, 2020) as well as more recently to engagement in self-care practices within helping professionals (Miller et al., 2019; Sirois et al., 2015). In order to more easily understand self-compassion as a concept, it is beneficial to explore the widely recognised concept of compassion. Compassion involves having an awareness of others' pain and being moved by, and sensitive towards, the suffering of others (Neff, 2003a). It involves treating others in a kind, caring and non-judgmental manner during times of distress (Goetz et al., 2010; Neff, 2003a) and having a desire to help alleviate the pain of others (Goetz et al., 2010; Macbeth & Gumley, 2012; Neff, 2003a; Neff & Dahm, 2015). Self-compassion then involves turning that compassion for others inwards and extending it towards oneself in times of suffering (Gilbert, 2014; Neff, 2003b). Being self-compassionate involves treating the self

with the same kindness, empathy and care that an individual would show a close friend in need (Neff, 2003b; Terry & Leary, 2011).

Originally derived from Buddhist philosophy, self-compassion was first operationalised for use within western psychology by Neff (2003b) as a healthy way of self-relating during times of suffering or distress whereby individuals attempt to mitigate their suffering in an empathetic, caring and non-judgmental manner. Self-compassion involves an individual's awareness of their suffering and the motivation to act to mitigate that suffering (Neff, 2016, 2023b). Neff's (2003b) construct of self-compassion is proposed to involve three interrelated components: self-kindness compared to self-judgement, common humanity compared to isolation, and mindfulness compared to over-identification. The components of self-compassion (and thus, the construct of self-compassion itself) are thought to enhance an individual's resilience to personal stressors and suffering (Neff, 2003b).

Self-Kindness versus Self-Judgement

The first component of self-compassion focuses on how one responds to their own suffering or failure, either with self-kindness and understanding or with self-criticism and judgement (Neff, 2023b). Responding with self-kindness involves the ability to take a caring and understanding perspective in response to one's own suffering (Neff, 2003b). Individuals who exhibit self-kindness offer themselves comfort in the form of unconditional acceptance, warmth and empathy without engaging in judgement or blame for their current circumstances (Barnard & Curry, 2012; Nelson et al., 2018). Self-judgement on the other hand involves individuals taking a harsh, self-critical and judgemental attitude towards oneself during times of distress or failure. Self-judgement can result in individuals placing blame on themselves for their suffering and having less motivation to alleviate their pain (Neff, 2003b). Importantly, self-kindness is not merely the absence of self-criticism; it involves genuine concern for one's suffering along with a sincere wish to reduce this suffering (Neff, 2023b).

Common Humanity versus Isolation

Common humanity as opposed to isolation involves how an individual perceives their situation, as being part of the wider human experience or as a unique, isolating circumstance. By perceiving one's experience as part of the wider experience, one acknowledges that everyone experiences suffering and failure, as we are all human (Neff, 2003b; Nelson et al., 2018). Further, an individual experience of suffering is considered a moment of suffering that another member of humanity has experienced at one time (Neff, 2003b; Nelson et al., 2018); we are all interlinked, and our experiences are shared. The shared nature of humanity creates a sense of unity which enables individuals to view their circumstances as part of a common human experience, to see their pain or inadequacies as part of a shared human condition rather than an individual flaw or weakness (Neff, 2023b). Viewing suffering as a shared human experience is critical for being able to be open to and accepting of one's own experience in times of suffering. Contrastingly, when an individual perceives their circumstances as an isolating experience, they irrationally view any failures or negative events as unique, personal experiences (Neff, 2003b). Isolation leads individuals to false beliefs that they are the only one to experience failure or suffering and that they are alone in their distress. Viewing suffering as an isolating experience can result in an exacerbation of the suffering experience (Neff, 2023b).

Mindfulness versus Over-Identification

The third, and most vital, aspect of self-compassion involves the attention one gives to painful experiences. This attention can occur on a continuum ranging from mindful to overly identified attention. (Neff, 2023b). Mindfulness in the context of self-compassion refers to having an awareness and acceptance of one's own feelings in response to the personal suffering experience without over-identifying with or attaching judgement to them (Neff, 2003b). It involves being able to sit with one's thoughts and feelings related to their suffering experience, simply observing and acknowledging them for what they are (e.g. emotions and cognitions) rather than focusing on the specific content of one's

thoughts and feelings or reacting to them (Germer & Neff, 2019; Neff, 2023b). This balanced awareness enables individuals the time and ability to candidly engage with their experience, and see the reality of the situation, by not trying to hide from their feelings or control their suffering experience, despite how unsettling it may be (Germer & Neff, 2019; Neff, 2023b). This enables individuals to see failures or inadequacies as a moment in time and be able to acknowledge their associated feelings while not ruminating in feelings of defeat or imperfection. Comparatively, individuals who over-identify with feelings tend to narrowly focus their attention and often magnify failures and inadequacies which leads to an intensification of the suffering experience. Over-identification prevents an individual from developing a balanced view of their experience, a perspective which is vital for engaging in self-care and compassion towards the self (Neff, 2023b).

Self-compassion and its components form a continuum that ranges from compassionate (self-kindness, common humanity, and mindfulness) through to uncompassionate (self-judgement, isolation, and overidentification) responses to one's own suffering (Neff, 2016, 2023a). Consequently, individuals can relate to themselves in varying degrees depending on how they fall on the continuum for each component. A greater self-compassionate response involves the existence of one component and the absence of the other for all three components (Neff, 2016). For example, a self-compassionate individual would be high on self-kindness and comparatively low on self-judgement, high on common humanity and comparatively low on isolation, as well as high on mindfulness and comparatively low on over-identification.

Despite each aspect of self-compassion being distinct concepts, they are interlinked and interact with one another to contribute to the development of an overall self-compassionate mindset (Neff et al., 2021). For example, having greater mindful awareness helps to increase acceptance and reduce self-judgement. A reduction in self-judgement is linked to increases in self-kindness which reduces the impact of negative experiences on the self, thus enabling engagement in mindful awareness of one's

emotions and thoughts more easily (Neff, 2023a; Neff et al., 2021). Further, by viewing negative experiences and failures as shared, common experiences of humanity, one can relate to oneself with less blame and self-judgement. And relatedly, lowered self-judgement can help to reduce feelings of solitude and uniqueness of experience.

Self-Compassion and Mindfulness

It is important to distinguish between general mindfulness, mindfulness with respect to self-compassion and mindfulness as a self-care practice. Mindfulness involves deliberate awareness of the present moment and accepting any thoughts or experiences that come into consciousness without any judgement or reaction (Shapiro & Fitch, 2023). Mindfulness enables an individual to just sit in the present moment, gaining clarity to facilitate an unbiased perception of reality that allows an individual to respond to experiences in a balanced manner (Neff, 2023a). This concept of general mindfulness can be practised in relation to all experiences in life, both positive and negative; while mindfulness within self-compassion has a narrower scope and is specific to self-relation in times of suffering (Neff, 2023a; Neff & Dahm, 2015). It is used uniquely to assist an individual to maintain a balanced mindset in the face of personal suffering, in order to respond to oneself with necessary emotional support to alleviate that suffering. Further, mindfulness within self-compassion focuses on awareness of personal suffering (Neff, 2023a) and it is interlinked with, and unable to be separated from, community humanity and self-kindness (Germer & Neff, 2013). Mindfulness in the context of self-care, on the other hand, is distinct with regards to the intention behind it. Mindfulness as a self-care behaviour requires intentional and purposeful engagement, at specific times, with the aim of promoting holistic wellbeing and mitigating stress (Neff, 2023a) rather than solely with regards to suffering. In this way, mindfulness in the context of self-care has a narrower focus than mindfulness generally but a broader focus than mindfulness within self-compassion (Germer & Neff, 2013).

Benefits of Self-Compassion

Although a relatively new concept, interest in self-compassion has been growing given its links to many positive wellbeing outcomes. Interest and relevance for investigating self-compassion has also increased recently due to its utility, in that it can be taught or increased through training and psychological interventions (Ferrari et al., 2019; Germer & Neff, 2013; Gilbert, 2014; Neff, 2023a). Self-compassion has been purported to be a valuable intrapersonal resource that can protect against stress and enhance an individual's holistic wellbeing (Allen & Leary, 2010; Ferrari et al., 2019; Tiwari et al., 2020). Self-compassion has been positively associated with emotional regulation (Leary et al., 2007), coping and overall resilience (Kotera, Cockerill, et al., 2021; Kotera, Tsuda-McCaie, et al., 2021; Terry & Leary, 2011; Tiwari et al., 2020) as well as resilience in the face of illness (Sirois et al., 2015). It has been negatively associated with rumination (Hashem & Zeinoun, 2020; Neff & Vonk, 2009), avoidance (Krieger et al., 2013) and negative affect (Leary et al., 2007). Further, self-compassion has been widely linked to decreased psychopathology (Krieger et al., 2016; Macbeth & Gumley, 2012; Neff & Dahm, 2015), stress (Beaumont et al., 2016; Finlay-Jones et al., 2015; Raes, 2010) and self-criticism (Neff, 2003b). It has also been positively associated with increased happiness (Neff & Germer, 2013), life satisfaction (Barnard & Curry, 2012; Zessin et al., 2015), positive affect (Neff & Vonk, 2009), self-acceptance (Neff, 2003b), overall wellbeing (Beaumont et al., 2016; Neff & Vonk, 2009; Zessin et al., 2015) and competence in delivering compassionate care (Kemper et al., 2020).

Self-Compassion and Health Promoting Behaviours

More recently, self-compassion has been highlighted as an important factor linked with engagement in health promoting behaviours generally (Bluth & Neff, 2018; Dunne et al., 2018; Sirois et al., 2015; Terry & Leary, 2011) and self-care practices specifically (Miller et al., 2019; Mills et al., 2018; Patsiopoulos & Buchanan, 2011). Self-compassion has been linked to greater medical adherence in individuals with diabetes (Ferrari et al., 2017; Friis et al., 2016), cancer (Sirois & Hirsch, 2019), chronic

fatigue (Sirois & Hirsch, 2019) and HIV (Brion et al., 2014). It has also been linked to improvements in disordered eating (Ferreira et al., 2013) and eating regulation (Guertin et al., 2020) as well as reduced shame and binge-eating (Duarte et al., 2021) among individuals with eating disorders.

Further, self-compassion has been linked with improvements in physical health and exercise behaviours (Sirois et al., 2015; Terry & Leary, 2011). Specifically, self-compassion has been positively linked to improved engagement in goal-directed health behaviour and health monitoring (Biber & Ellis, 2019). A prior meta-analysis by Sirois et al. (2015) found higher self-compassion to be linked to increased frequency of engagement in health promoting behaviours of exercise, sleep, healthy eating and stress management. Indicating the significance of self-compassion for improving individual engagement in key health behaviours. However, the majority of research has focused on the role of self-compassion in improving engagement in specific, unique health behaviours such as healthy eating or medical adherence in the context of illness (Ferrari et al., 2017; Friis et al., 2016; Sirois et al., 2015).

Limited research has investigated the role of self-compassion more explicitly in promoting engagement in more general, holistic health behaviours such as self-care within helping professionals. Patsiopoulos and Buchanan (2011) qualitative study investigated self-compassion's link with health behaviours, including self-care practices more generally. They found that Canadian counsellors perceived self-compassion to be associated with a greater motivation to improve one's wellbeing and engage in behaviours or take steps to promote one's health. One counsellor specifically described self-compassion as "an attitude or a perspective that you shift within yourself, which can translate into self-care actions" (Patsiopoulos & Buchanan, 2011, p. 305), highlighting the positive connection between self-compassion and self-care.

Only two recent studies have focused more specifically on directly investigating the link between self-compassion and self-care behaviours. A study by Mills et al. (2018) found preliminary evidence for a positive relationship between self-compassion and self-care ability in a sample of

Australian palliative care doctors and nurses ($r=.412$, $p<.001$). Similarly, Miller et al. (2019) found that greater self-compassion was linked to greater engagement in both personal and professional self-care practices in American social workers. Specifically, they found that self-compassion was the strongest predictor of social workers' engagement in self-care, with self-compassion uniquely explaining 19.5% and 16.9% of the variance in social workers' engagement in personal and professional self-care respectively. Despite the scarce literature base, these findings highlight the potential utility that self-compassion may have in improving self-care engagement for helping professionals. Additional research is needed to contribute to the limited literature as well as investigate whether this relationship holds across populations and contexts.

Self-Compassion and Burnout

Interestingly, self-compassion has also been independently linked to stress and burnout in several helping professions. Higher self-compassion has been found to be associated with reduced burnout in United States clergy (Barnard & Curry, 2012) and medical healthcare professionals including physicians, nurses, medical residents, student midwives and paediatric residents (Abdollahi et al., 2020; Beaumont et al., 2016; Dev et al., 2020; Dev et al., 2018; Hashem & Zeinoun, 2020; Kemper et al., 2020). A recent cross-sectional and longitudinal study found that self-compassion was associated with lower burnout and predicted reduced stress over time in a sample of paediatric residents (Kemper et al., 2020). Further, an intervention study by Eriksson et al. (2018) found that self-compassion training resulted in greater levels of self-compassion and consequently lower perceived stress and burnout among psychologists. Consequently, increased self-compassion could also be a protective factor for helping professionals against the development of chronic stress outcomes such as burnout.

Self-compassion has been linked with promoting general stress resilience among helping professionals (Finlay-Jones et al., 2015; Kemper et al., 2020; Neff, 2003b, 2023b). Studies have shown that individuals who have greater self-compassion have a lower likelihood of responding strongly to

negative events and stressors (Neff, 2003b; Neff et al., 2007; Terry & Leary, 2011). Finlay-Jones et al. (2015) explored self-compassions link with stress in a sample of Australian psychologists. They found that greater self-compassion was associated with decreased stress symptoms in this population. Of note, self-compassion has been found to reduce the link between burnout and lower quality of patient care in medical professionals (Tawfik et al., 2019). Therefore, self-compassion may offer additional benefits beyond enhancing self-care and reducing burnout by not only being protective for helping professionals but also for their clients (Pavlova & Consedine, 2023).

Self-Compassion and Self-Care

The explicit link between self-compassion and self-care has not been thoroughly investigated. To date, one of the only studies that has specifically investigated a link between self-compassion and self-care reported that self-compassion may improve helping professionals' engagement in self-care practices (Miller et al., 2019). Despite this limited research base, there is arguably instinctive theoretical links between the two concepts. Both self-compassion and self-care involve increased awareness and motivation or an action to promote one's own wellbeing. Effective self-care involves having awareness of one's own needs (Collins, 2005; Richards et al., 2010) and taking active steps to pursue resources that will promote holistic wellbeing (Colman et al., 2016; Posluns & Gall, 2020; Rupert & Dorociak, 2019). Similarly, self-compassion, by its very nature, aims to increase an individual's ability to recognise, appreciate, and be aware of one's own suffering, as well as an active motivation and genuine desire to alleviate this suffering (Norcross & VandenBos, 2018; Pavlova & Consedine, 2023).

Given the similarities between these constructs, one could argue that being more self-compassionate is linked to greater engagement in self-care. Specifically, the action or motivation to alleviate the suffering component of self-compassion could promote engagement in self-care practices (Neff, 2023a). This can be seen in research that has investigated behaviours that appear generally to fall under the umbrella of self-care behaviours. Specifically, individuals with greater self-compassion are

more likely to act and engage in positive health management behaviours for personal wellbeing (Homan & Sirois, 2017; Sirois et al., 2015), enjoyable activities for fun or stress relief (Neff, 2023a) as well as self-improvement behaviours for ensuring competence (Gunnell et al., 2017) and personal growth (Neff, 2023a).

Within the context of psychologists, it is possible that self-compassion may further aid self-care behaviours by influencing the barriers to self-care engagement prominent in this population. The lack of self-care within psychologists, as well as the general population, has been documented to be associated with factors such as the perception of self-care for the therapist as selfish, a lack of awareness to psychologists own self-care needs, stigma associated with therapists help seeking, feelings of embarrassment at needing external support as well as fear of failure or being deemed incompetent (Dattilio, 2015; Norcross & VandenBos, 2018; Smith & Moss, 2009). Self-compassion may be especially crucial for helping professionals who are commonly acknowledged to prioritise the care of others over care of oneself (Norcross & VandenBos, 2018). Individuals with greater self-compassion are more likely to perceive struggles or stress as part of the wider human experience (common humanity), they are less likely to be self-critical when faced with their own shortcomings or support needs (self-kindness), and they are more likely to maintain self-awareness of their own needs and actions or inactions (mindfulness). In this way, self-compassionate psychologists may be more likely to notice when they are struggling (Colman et al., 2016; Pakenham, 2017), be more accepting of reaching out and asking for help, more able to take time to care for themselves without feeling selfish or guilty (Norcross & VandenBos, 2018), and be kinder to themselves in instances where they may not achieve their self-care goals. Self-compassion may not only motivate individuals to engage in self-care strategies but it may also help to remove barriers to self-care engagement by enabling individuals to view themselves as worthy of personal investment and care despite setbacks, negative connotations, difficulties, or fear of stigma (Neff, 2023a; Neff & Pommier, 2013).

It is also important to note that despite these similarities and intuitive link, self-compassion and self-care do in fact represent distinct constructs and warrant independent investigation. Although both are inherently positive practices, self-care is an external practice that one must find the time and energy to engage in (Pavlova & Consedine, 2023). Self-compassion on the other hand is an internal way of self-relating in times of suffering (Neff, 2003b) that may not require the same commitment (Neff et al., 2020; Pavlova & Consedine, 2023). Further, the purpose of, and types of activities within self-compassion and self-care differ. Self-compassion relates specifically to personal suffering and actions engaged in focus solely on alleviating that suffering (Neff, 2023a; Pavlova & Consedine, 2023). Self-care, on the other hand, is both more general and specific; it commonly relates to engaging in a wide variety of practices thought to improve one's overall wellbeing, yet it can also refer to specific health behaviours such as in the context of health management (Dorociak, Rupert, & Zahniser, 2017; Sirois et al., 2015).

Summary

Overall, the literature provides support for the role that self-compassion may play in ameliorating the negative consequences of stress and enhancing engagement in self-care. However, additional research is needed to investigate these relationships and findings, as to date the relationship between self-compassion, self-care and burnout collectively has yet to be examined. There have only been two studies to date that directly examine the relationship between self-compassion and self-care specifically. This dearth of literature provides a growing need to further address these limitations and add to this body of literature in additional populations. Given the vast benefits of self-care and the need to encourage engagement in these practices, it is of importance to replicate the original study by Miller et al. (2019) to determine whether the same relationships are found within additional populations.

A key population of interest is psychologists, as the literature indicates that their engagement in self-care practices may be limited. This poses concern given the aforementioned negative consequences of lack of self-care for both psychologists and their clients. Given the risk of burnout in this population,

the ethical imperative for self-care and the tendency of psychologists to put others' needs before their own (Barnett et al., 2007; Finlay-Jones et al., 2015; McCormack et al., 2018), there is surprisingly limited research investigating self-care engagement in this population and none focusing on factors that may improve self-care engagement. Further, general research on the incidence of burnout and level of engagement in self-care practices in New Zealand and Australian psychologists is particularly sparse (Di Benedetto & Swadling, 2014). The majority of burnout literature focuses on those professionals in general business professions or specific medical professions such as doctors, nurses and psychiatrists (Kumar et al., 2011; Milfont et al., 2008; O'Connor et al., 2018; Simionato & Simpson, 2018).

This study will contribute to this limited literature base and provide unique findings not only for psychologists but those specifically in a New Zealand and Australian context. The findings could have important implications for the Australasian psychology profession as a whole and for individual psychologists in terms of ways to reduce negative stress outcomes and influence self-care engagement. Further, this study could inform future research directions within the literature to incorporate new ways of thinking about burnout prevention.

Aims

The study will explore the relationships between self-compassion, self-care and burnout in New Zealand and Australian psychologists. Specifically, it will investigate whether self-compassion may be a factor by which psychologists' engagement in self-care practices can be increased. A further aim of this study will be to explore the relationship that both self-care and self-compassion have independently with burnout. A core aim of this study will be to examine whether self-compassion may strengthen (moderate) the relationship between self-care practices and incidence of burnout in New Zealand and Australian psychologists.

Hypotheses

1. There will be a positive relationship between psychologists' level of self-compassion and their engagement in personal self-care.
2. There will be a positive relationship between psychologists' level of self-compassion and their engagement in professional self-care.
3. There will be a negative relationship between psychologists' level of both self-care engagement and self-compassion and their level of burnout.
4. Self-compassion will strengthen the association between self-care and burnout. In other words, it is expected that high scores of self-care would have a negative relationship with burnout, but this relationship would be stronger for those with high self-compassion.

Chapter 3: Methods

Research Overview

The survey designed for use in this research was cross-sectional and quantitative in nature. The primary participants for this study were New Zealand psychologists. Due to an initial difficulty in recruitment, the research was opened up to Australian psychologists in order to increase the sample size. Participants were emailed a link to complete the survey online. Participants needed to be registered with the New Zealand or Australian Psychologists Board and hold a current practicing certificate in order to be eligible to participate. There were two versions of the survey for New Zealand (Appendix A) and Australian (Appendix B) participants; both surveys contained 59 items inclusive of items confirming participant eligibility and consent along with demographic items and three subscales measuring self-compassion, personal and professional self-care, as well as client-related, work-related and personal burnout. There were slight variations in demographic and screening variables for the New Zealand and Australian survey; for example, additional ethnicity choices for the Australian version (i.e. Aboriginal and Torres Strait Islander). The survey could be completed in approximately 15 minutes. Qualtrics survey software was used to collect and store participant responses on a secure Massey University computer server. The online survey could be accessed from 16 November 2022 to 16 May 2024.

Procedure

Initially, non-probability purposive sampling was used to select the New Zealand Psychological Society (NZPS) and the New Zealand College of Clinical Psychologists (NZCCP) as contact organisations for participant selection. This was done to ensure that participants were registered psychologists; as National bodies, it was expected this would result in a representative sample of New Zealand Psychologists. In the first instance, the NZPS (Appendix C) and the NZCCP (Appendix D) were sent an email asking for assistance with advertising the study to their members which included an invitation to

participate. Both organisations chose to advertise the study to their members via their monthly organisation newsletter. Due to low response, the survey was opened up to Australian psychologists in an attempt to increase sample size. To target Australian psychologists, non-probability purposive sampling was used to select the Australian Psychological Society (APS) as a contact organisation for participant selection. The APS was sent an email asking for assistance with advertising the study within their organisation (Appendix E). Secondary recruitment occurred by advertising the research on the APS psychXchange website from 06 January 2024 – 20 April 2024 and across New Zealand via the NZCCP directly emailing their members an invitation to participate in the study on 23 April 2024.

The invitation to participate contained a link to the survey (Appendix F) and outlined the nature and objective of the study including the inclusion criteria as well as the voluntary, anonymous nature of participation. Before commencing the survey, an information sheet was provided to participants. This detailed further information on the aims and purpose of the research, what participation would involve, including ethical considerations and the rights of participants, as well as the contact details of the researcher for further questions.

Ethics and Informed Consent

Massey University's Human Ethics Committee: Southern A, Application 22/04 reviewed and approved this research project on the 03/07/22 (Appendix G). The core ethical considerations for this research focused on informed consent, confidentiality and the reduction of harm. Before commencing the survey, participants confirmed they had read and comprehended the information sheet and that they consented to engage in the research. Participants were informed that, if they chose to participate, they could choose to not answer any questions and due to the nature of the survey, all answers would be anonymous. They were also advised that they were under no obligation to engage in the research, but that by choosing to continue, their engagement in the survey implied consent.

Upon completing the survey, participants had the choice to continue on to a separate, secure window to provide their email and go in the draw to win a \$50 voucher and/or receive a summary of the results. It was not expected that participation would cause distress; however, prior to completing the survey (and again at the end of the survey), participants were encouraged to talk to their supervisors or contact one of the provided support lines if they experienced any discomfort while completing the survey.

Participant Characteristics

To meet the inclusion criteria, participants had to be registered with either the New Zealand or Australian psychologists board and hold a current practicing certificate. Of the participants in the current study (n=197) 22 (11.2%) identified as male, 172 (87.3%) identified as female and 1 (0.5%) identified as non-binary. A further two participants did not disclose their gender identity. The age ranges in the current study were fairly evenly split with almost half aged 40 and below (47.7%) and just over half aged above 40 (51.9%). The majority of participants were aged between 36 - 40 years (17.8%), with a similar number of participants aged 46 – 50 years (16.8%). Only 4 participants (2%) indicated they were between 20 – 25 years. Over half of the sample indicated they identified as Pākehā/New Zealand European (66%), while only 7.1% identifying as Māori, 4.6% as Australian European, 4.1% as Asian, 2% as African, .5% as Pasifika and 15.7% as other ethnicity. Nearly half the sample worked in private (45.1%) settings and over a third worked in government/health funded (38.5%) settings, with only 6.6% working in non-government, 9.4% in education, 13.2% in both government and private, 0.4% working in other settings.

The majority of participants indicated that they worked more than 30 hours per week with 19.3% working 31 – 35 hours per week, 36% working 36 – 40 hours per week and 16.2% working more than 40 hours per week. A further 28.4% worked 30 hours or less per week. Nearly a third of participants indicated they were fairly new to working in psychological practice, with 29.9% working

between 0 – 5 years in the field. The rest of the participants indicated they had worked between 6 – 10 (22.3%), 11-15 (11.2%), 16 – 20 (12.2%) and more than 20 (24.4%) hours per week in psychological practice. The vast majority of participants worked as clinical psychologists (70.1%), with only 14.2% identifying as psychologists (general), 4.6% as trainee/intern psychologists, 6.1% as educational psychologists, and 2.5% as counselling psychologists or neuropsychologists. The full breakdown of participant characteristics can be seen in Table 1.

Table 1

Sociodemographic Characteristics of Participants

Participant characteristics	<i>N</i>	Proportion (%)
Gender		
Male	22	11.2%
Female	172	87.3%
Non-binary	1	0.5%
Missing	2	1.0%
Ethnicity		
Pākehā/New Zealand European	130	66%
Māori	14	7.1%
Pasifika	1	0.5%
Asian	8	4.1%
African	4	2.0%
Australian European	9	4.6%
Other	31	15.7%
Age		
20 – 25 years	4	2.0%
26 – 30 years	28	14.2%
31 – 35 years	27	13.7%
36 – 40 years	35	17.8%
41 – 45 years	15	7.6%
46 – 50 years	33	16.8%
51 – 55 years	21	10.7%
56 – 60 years	12	6.1%
Greater than 60 years	21	10.7%
Missing	1	0.5%
Scope of Practice		
Psychologist	28	14.2%

Participant characteristics		<i>N</i>	Proportion (%)
	Intern/Trainee Psychologist	9	4.6%
	Counselling Psychologist	5	2.5%
	Clinical Psychologist	138	70.1%
	Neuropsychologist	5	2.5%
	Educational Psychologist	12	6.1%
Years in Psychological Practice			
	0 – 5 years	59	29.9%
	6 – 10 years	44	22.3%
	11 – 15 years	22	11.2%
	16 – 20 years	24	12.2%
	20+ years	48	24.4%
Hours in Psychological Practice (H/W)			
	0 - 5	1	.5%
	6 - 10	2	1.0%
	11 - 15	5	2.5%
	16 - 20	11	5.6%
	21 - 25	14	7.1%
	26 - 30	23	11.7%
	31 - 35	38	19.3%
	36 - 40	71	36%
	40+	32	16.2%
Work Setting			
	Government/health funded	99	38.5%
	Non-government	17	6.6%
	Private	116	45.1%
	Education	24	9.4%
	Other	1	0.4%

Measures

The primary constructs measured in this survey were self-compassion, personal and professional self-care, as well as client-related, work-related and personal burnout. In addition to these primary constructs, the survey also measured seven control variables. These variables consisted of age, gender, ethnicity, scope of practice, work setting, years working in psychological practice, and hours per week working in psychological practice.

Of the control variables, ethnicity and work setting allowed for participants to select multiple responses based on which categories were relevant to them. To utilise the data in a meaningful way for future statistical analyses, both variables were recoded. Participants ethnicity was recoded in line with

'prioritised ethnicity' of responses (Statistics New Zealand, 2005). The level of prioritised ethnicity for this sample was as follows (from first to last priority): Māori, Pasifika, Asian, African, Other, Pākehā/New Zealand European, Australian European. For example, if a participant identified as both Māori and Pākehā/New Zealand European then their response was reclassified as Māori. Aboriginal/Torres Strait Islander, Middle Eastern and Latin American were not included for recoding purposes as no participants identified with these ethnicities in the dataset. Similarly, work setting was recoded into the following settings: government only, non-government only, private only, education, government and private, non-government and private, other/multiple settings.

Self-Compassion - Scale Short Form (SCS-SF)

The Self-Compassion Scale - Short Form (SCS-SF; Raes et al., 2011) is a 12 item self-report measure which assesses how often individuals engage in compassionate or uncompassionate responses to self (Neff, 2003a). The SCS-SF is a reliable reduction from the 26 item, original self-compassion scale (SCS). There is very high correlation between both scales ($r \geq .97$) (Raes et al., 2011). The SCS-SF consists of six subscales which measure the different dimensions that make up self-compassion according to Neff (2003a). These dimensions are self-kindness, mindfulness, common humanity and the reverse-scored dimensions of self-judgment, isolation, and over-identification. Participant responses are scored on a five-point Likert scale indicating the frequency in which they behave in the stated manner. Scores range from 1 = Almost Never to 5 = Almost Always. Items on three of the six dimensions are reverse scored; over-identification (1,9), isolation (4,8), and self-judgment (11,12). When using the SCS-SF, due to there only being two items per scale and the lower reliability of individual subscale scores, it is recommended to only use a total global score of self-compassionate responding (Neff & Dahm, 2015; Raes et al., 2011). To calculate a global measure of self-compassion, the mean of each subscale is calculated and then used to calculate an overall mean (the average of the six subscale means) which can range 1-5. The SCS-SF has no clinical norms; as such, scores ranging from 1-2.5 indicate low self-compassion, while 2.5-3.5

indicates moderate self-compassion and 3.5-5.0 indicates high self-compassion (Raes et al., 2011). The validity and reliability of the SCS-SF factor structure has been found to hold across a number of diverse cultures and populations including psychologists (Finlay-Jones et al., 2015; McCade et al., 2021). The internal consistency of the SCS-SF is high (Cronbach's $\alpha \geq .86$) as is the content, convergent, divergent and face validity of the scale (Neff, 2016; Raes et al., 2011). The Cronbach alpha coefficient in the current study was .88.

Self-Care Practices Scale (SCPS)

The Self-Care Practices Scale (SCPS; Lee et al., 2020) is a self-report scale incorporating 18 items that assesses the frequency in which an individual engages in professional and personal self-care behaviours. The SCPS was developed for use with social workers and other helping professionals (Lee et al., 2020). The SCPS is made up of two subscales; personal self-care (9 items) and professional self-care (9 items), consistent with the original framework proposed by Lee and Miller (2013). The personal self-care subscale includes items that assess an individual's engagement in physical activity, laughter and quality time with others. The professional self-care subscale includes items that assess an individual's engagement in saying 'no' when necessary, work-related problem solving, as well as taking breaks and holidays. Participants respond on a five point Likert scale to indicate how often they engage in each self-care behaviour (Lee et al., 2020). Scores range from 0=never to 4=very often. The SCPS generates three scores; a cumulative personal self-care score (0 - 36), a cumulative professional self-care score (0 - 36), and an overall score calculated by combining the individual's personal and professional self-care scores (0 - 72) (Miller et al., 2018). The SCPS has good internal consistency (Full SCPS $\alpha = .87$, personal self-care subscale: $\alpha = .81$ and professional self-care subscale: $\alpha = .78$) (Lee et al., 2020). Confirmatory factor analyses found all factor loadings of the 18 item SCPS were statistically significant and supported the shorter model as an acceptable fit for professional and personal self-care factors (Lee et al., 2020). The

Cronbach alpha coefficient for the current study was .74 for professional self-care, .83 for personal self-care, and .87 for total self-care.

Copenhagen Burnout Inventory (CBI)

The Copenhagen Burnout Inventory (CBI; Kristensen et al., 2005) is a 19-item questionnaire that measures burnout with three subscales: personal burnout (6-items), work-related burnout (7 items), and client-related burnout (6-items). The personal burnout subscale measures general physical and psychological exhaustion; the work-related burnout subscale measures psychological and physical exhaustion related to work; and the client related burnout subscale measures exhaustion directly related to client work (Kristensen et al., 2005). Participants respond to these items on a five-point scale ranging from 1=always to 5=never/almost never. Responses are then re-coded into the original labels of 100 (always), 75, 50, 25 (never/almost never), where higher scores indicate greater burnout (Kristensen et al., 2005). A total score for each subscale is calculated by averaging scores for each question within that subscale. Researchers have also found evidence to support combining the three components into a global burnout measure including in a New Zealand study (Milfont et al., 2008). This global score is calculated by averaging all subscale scores (Di Benedetto & Swadling, 2014; McCade et al., 2021; Milfont et al., 2008). The CBI has high internal consistency with personal burnout $\alpha = .87$, work-related burnout $\alpha = .87$, and client-related burnout $\alpha = .85$ (Kristensen et al., 2005). The Cronbach alpha coefficient for the current study was .85 for personal burnout, .84 for work-related burnout, .89 for client-related burnout and .92 for overall burnout. The CBI has been found to have good predictive and concurrent validity (Kristensen et al., 2005). It has been used in a variety of populations and various countries including Australian psychologists (Di Benedetto & Swadling, 2014; McCade et al., 2021) and New Zealand Teachers (Milfont et al., 2008). Milfont et al. (2008) found the CBI to have good construct validity in their use with a New Zealand population.

Data Analysis

All analyses run in this research, except the power analysis, were conducted using Statistical Package for Social Sciences (SPSS) Version 29. G*Power version 3.1.9.7 was used to conduct the power analysis. SPSS was used for pre-screening to assess all assumptions of regression and moderation as well as to run three hierarchical regression models to provide evidence for hypothesis 1, 2 and 3. Specifically, the hierarchical regression models assessed self-compassion as a predictor of professional self-care (model 1), self-compassion as a predictor of personal self-care (model 2) and self-care and self-compassion as predictors of burnout (model 3). A simple moderation model (model 1) was run to provide evidence for hypothesis 4 using Hayes (2022) PROCESS marco. Specifically, moderation analysis was used to assess self-compassion as a moderator of the relationship between self-care and burnout (model 4). Initial screen was used to determine significant covariates to include in each corresponding model.

Chapter 4: Results

Initial screening and exploration

Power Analysis

Prior to any analysis, G*Power (version 3.1.9.7; Faul et al., 2009) was utilised to determine the required sample size for a medium effect ($f^2 = .15$; Cohen, 1992) in a regression model with 8 predictors. This ensured that possible covariates could be included. A total sample size of 109 participants was required when using an α of .05, and target power of .80. The sample size of this research ($n = 197$) exceeded the minimum requirement for sufficient power.

Missing Data

The total number of responses in the initial dataset consisted of 213 (New Zealand) and 11 (Australian) participants. An initial screen of the data revealed that there were 17 (New Zealand) and 1 (Australian) participant who did not complete any questions due to either not providing consent or not meeting eligibility criteria (currently registered and practicing). These were therefore removed from the dataset leaving 196 (New Zealand) and 10 (Australian) participants. Cases missing 50% or more of one or more entire scales and/or subscales were deemed to not be suitable for analysis and were therefore excluded for the dataset. Consequently, a further nine participants were removed resulting in a total of 187 (New Zealand) and 10 (Australian) participants for SPSS Analysis.

Missing data for the primary measure items ranged from 0% to 1.5%. Specifically, missing data for SCS-SF ranged from .5% to 1.0% across items. There was no missing data from professional self-care items. Missing data for personal self-care items was .5 on two subscales. Missing data for personal burnout was .5 on one subscale. Missing data on the work-related burnout subscale ranged from .5% to 1.5% across items. Missing data on the client-related burnout subscale ranged from .5 – 1% across subscales. Missing data for demographic variables ranged from 0% - 1%, age had one missing data value at .5% while gender had two missing data values at 1%. Work setting and ethnicity variables allowed for

multiple response by participants, as such, to analyse missing data a multiple response set was created for each variable respectively. Both work setting and ethnicity contained no missing data. All other demographic variables had no missing data points.

Despite the small amount of missing data, Little's Missing Completely at Random (MCAR) was run to ensure that the missing data contained no systematic bias (Little, 1988). The MCAR result was non-significant ($\chi^2 = 196.31$, $df = 171$, $p = 0.09$), indicating no systematic bias and that the missing data was in fact random with no systematic bias. Due to only a small number of missing data points and that the missing data was completely random, it was deemed that the missing data would be of very little risk to analysis and consequently imputation methods would be comparable (Tabachnick, 2019). Given the nature of the data set, listwise deletion was not appropriate for the core scales. However, it was utilised for the significant demographic variables with missing data (age) in later analysis. For the core scales with missing data, the missing data points were replaced with the mean of the individual's response for relevant scales and subscales. Using the mean for data imputation of missing scores is conservative and offers a best guess in the absence of additional information (Tabachnick, 2019). After imputing the data, correlation of both the imputed and non-imputed scales were compared to ensure that the mean substitution would not impact subsequent analysis. There were no significant differences between the imputed and non-imputed scales. Consequently, the imputed scales were used in further correlation and moderation analyses.

Descriptive Statistics and Univariate Analyses

Normality

Normality of the data was first assessed via Shapiro-Wilk and then further via exploration of individual histograms. Initial analyses revealed that burnout ($D(197) .099$, $p = .095$), professional self-care ($D(197) .099$, $p = .23$) and total self-care ($D(197) .099$, $p = .289$) were normally distributed. Results for self-compassion ($D(197) .098$, $p = .01$) and personal self-care ($D(197) .098$, $p = .005$) on the other

hand indicated possible non-normal distributions. Histograms and Normal Q-Q plots for self-compassion and personal self-care however, showed no major concerns with skewness or normality of the data, with both appearing approximately normal.

Self-compassion and all self-care both showed slight negative skew and slight negative kurtosis, while burnout showed minor positive skew and negative kurtosis. All skewness and kurtosis statistics were below .5. Given the sample size ($n = 197$) the risk of non-normal distribution and the impact of skewness was deemed of minimal concern in line with the central limit theorem (Tabachnick, 2019). Regardless of a data sets distribution, the central limit theorem states that as sample sizes increase above $n \geq 30$ the distribution of the data will increasingly resemble a normal distribution (Field, 2018; Tabachnick, 2019). Similarly, any potential negative impact of kurtosis is diminished in larger sample sizes ($n > 100$) (Tabachnick, 2019). Consequently, given the sample size of this research ($n = 197$), along with no concerns in the visual inspection of the histograms or normal Q – Q plots, meant there were no concerns with normality of the current data set.

Univariate Outliers

Initial screening for univariate outliers was conducted via visual inspection of boxplots and histograms as well as through assessing z-scores. Visual inspection indicated that one participant's burnout score and one participant's professional self-care score could be of possible concern. The two cases were examined to confirm there were no errors in the data and that the responses were true possible responses. Once it was confirmed there were no issues with the data entry, Z-scores were checked to determine if these scores should be investigated further. As per Tabachnick (2019), z-scores that were over 3.29 are considered to be of possible concern. All z-scores were less than 3.29 and as such, the participants scores were not deemed of concern and were included in the analysis. Given there was no concern of univariate outliers in the data, nor were there any major concerns with skew or normality of the data, no transformations were deemed necessary. Further, as there were no

differences between the imputed and non-imputed data, the imputed data set was utilised for all future analyses unless stated otherwise.

Table 2 shows descriptive statistics and internal consistency of imputed data for the core variables (self-care, self-compassion, and burnout). The average level of total self-care for psychologists was 49.1, with scores of 25.2 and 23.8 for professional and personal self-care respectively. The mean level of self-compassion was 3.4 and the mean burnout level was 42.8, with a mean rating of 51.2, 46.0 and 31.3 for personal burnout, work-related burnout and client-related burnout respectively. Based on Kristensen et al. (2005) guide that a 5-point difference between subscales indicates a significant difference, psychologists in this study scored significantly higher on personal burnout compared to work-related burnout and client-related burnout. Further, they scored significantly worse on work-related burnout compared to client-related burnout. Consequently, New Zealand and Australian psychologists in this study engaged in self-care practices only moderately and were worse at engaging in personal self-care compared to professional self-care. Similarly, psychologists scored only moderately on self-compassion, indicating room for improvement for both self-care and self-compassion. New Zealand and Australian psychologists in this study scored moderately on burnout, with highest scores on personal and work-related burnout compared to client-related burnout. Within the sample, 67.5% met the criteria for low burnout, 26.4% met the criteria for moderate burnout and 3.0% met the criteria for high burnout. Overall, 29.5% of psychologists in this study met the criteria for burnout as per Kristensen et al. (2005).

Table 2

Core Variables Descriptive Statistics

Variable	N	Minimum	Maximum	Mean	SD	α
SCS-SF Total	197	1.67	4.75	3.44	.68	.88

Variable	N	Minimum	Maximum	Mean	SD	α
SCPS Total	197	21.00	72.00	49.06	9.90	.87
Personal Self-Care	197	8.00	36.00	23.84	6.08	.83
Professional Self-Care	197	10.00	36.00	25.22	4.83	.74
CBI Total	197	10.52	87.90	42.84	15.53	.92
Burnout Personal	197	12.50	95.83	51.24	17.37	.85
Burnout Work	197	10.71	92.86	45.98	16.75	.84
Burnout Client	197	.00	100.00	31.28	20.55	.89

Note. Table displays the imputed data rounded to 2dp.

N (listwise sample size) SD (standard deviation) and α (Cronbach Alpha Coefficient)

Bivariate Analyses and Data Screening

In order to assess linearity and homoscedasticity within the data, bivariate scatterplots between the core variables were analysed. For all core variables (SC, BO, Prof-SC, Pers-SC and Total SC), a linear relationship was apparent, with a straight line able to be fitted for all relationships. When professional self-care or personal self-care was plotted on the y-axis and self-compassion was plotted on the x-axis, a moderate positive relationship was apparent. When burnout was plotted on the y-axis and self-care or self-compassion on the x-axis, a moderate negative relationship was apparent. The spread of the data for all variables appeared random with no evidence to indicate the presence of heteroscedasticity. Pearson's product-moment correlation coefficients, showing the strength and direction of the relationships between the core variables, are represented in Table 3.

Table 3*Correlations of Core Variables*

Variable	SCS-SF	CBI – BO Total	SCPS - Total	SCPS – PerSC	SCPS – ProSC
SCS-SF	1				
CBI – BO Total	-.46**	1			
SCPS - Total	.50**	-.43**	1		
SCPS – Professional SC	.41**	-.36**	.88**	1	
SCPS – Personal SC	.49**	-.43**	.93**	.64**	1

Note. SCPS – PerSC (Personal Self-Care), SCPS – ProSC (Professional Self-care)

** $p < .001$

Correlations and significance of demographic variables were also assessed to determine their relevance for inclusion in further analyses; the results of which are represented in Table 4. Demographic variables were included in future regression and moderation analyses if they were found to have a significant relationship with the dependent variable for the corresponding analysis. Categorical demographic variables were either dichotomised or dummy coded as is a requirement for regression and moderation analysis (Tabachnick, 2019). Gender was dichotomised into male and female; the one participant who identified as non-binary was excluded from gender for further analysis given the requirement of dichotomisation along with a lack of any other participants within this category. Given the majority (70.6%) of the sample was European (either New Zealand European or Australian European) along with the low percentage of participants in some of the ethnicity categories, ethnicity was dichotomised into European or non-European. Similarly, given the majority of respondents were clinical psychologists (70.1%), scope of practice was dichotomised into clinical psychologist or non-clinical psychologist.

Similar to previous research on psychologists (Kercher & Gossage, 2024), work-setting was further dichotomised into Private Setting or Government/Health Funded setting as the number of responses in some categories was deemed too low for effective dummy coding. The decision was made to reduce and dummy code the variables of years spent working in psychological practice, hours per week spent working in psychological practice and age into three groups respectively. The groups were decided based on percentage split within the responses for each variable and guidance from prior research (Di Benedetto & Swadling, 2014; Kercher & Gossage, 2024). Years spent working in psychological practice was dummy coded into “less than 5 years” (29.9%), “6 – 15 years” (33.5%) and “more than 15 years” (36.6%). Hours per week spent working in psychological practice was dummy coded into “25 hours or less” (16.7%), “26 – 35 hours” (31%) and “more than 35 hours” (52.2%). Participants age was dummy coded into “35 years or less” (29.9%), “36 – 50 years” (42.2%) and “more than 50 years” (27.5%). As seen in Table 4, depending on analyses, the demographic variables that were significant were ethnicity, work setting, years spent working in psychological practice, hours spent working in psychological practice per week and participant age.

Table 4

Correlations of Covariates

Covariate	SCS-SF	CBI – Total	SCPS – Total	SCPS – PerSC	SCPS – ProSC
Gender	-.02	.08	-.08	-.07	-.08
Scope	-.12**	.09	-.10	-.09	-.10
Ethnicity	.24**	-.09	.15*	.16*	.10
Work Setting	-.13	.09	-.19**	-.18*	-.16*
Prac Years	.23**	-.18*	.11	.15*	.04
Age	.31**	-.27**	.16*	.17*	.10
Prac Hours	-.07	.12	-.16*	-.10	-.21**

Note. Prac Years (Years in psychological practice), Prac Hours (Hours per week spent working in psychological practice, SCPS – PerSC (Personal Self-Care), SCPS – ProSC (Professional Self-care)

* $p < .05$. ** $p < .01$

Multivariate Analyses: Assumptions for Moderation & Regression

For all models, the screening of multivariate data with regards to the assumptions of multiple regression was performed via a series of hierarchical multiple regressions. This was done as the PROCESS macro, which was utilised for moderation analyses, does not provide the required statistical output to enable assessment of the assumptions for moderation. These regressions enabled examination of the required residual plots and diagnostic data to confirm whether the required assumptions for regression and moderation had been met.

Homoscedasticity & Linearity

The scatterplot of standardised residuals versus standardised predicted values was inspected to assess linearity and homoscedasticity of the data. There were no concerns of uneven spread, and no systematic patterns were present in the data. The data was spread randomly between -3 and 3 on both axes, appearing roughly rectangularly distributed with concentrated scores around 0. Consequently, the data showed no concerns for meeting the assumptions for linearity and homoscedasticity/homogeneity of variance.

Independence of Errors

The Durbin-Watson test statistic assesses the assumption of the independence of errors. Scores close to 2 are deemed to indicate the independence of errors and scores below 1 and above 3 indicate a possible concern of autocorrelation (Field, 2018; Tabachnick, 2019). The Durbin-Watson's statistics for each model were as follows: Model 1 $D = 1.97$, Model 2 $D = 1.84$, Model 3 $D = 2.09$, Model 4 $D = 2.10$.

As all values were approximately 2, there was no indication of autocorrelation and as such there was no violation of the assumption of independence of errors.

Multicollinearity

Tolerance and Variance Inflation Factors were investigated to determine the presence of multicollinearity. Tolerance scores below .1 and/or VIF scores above 10 are used as a guide to indicate the possibility of multicollinearity between the variables (Pallant, 2020). All variables had VIF or tolerance scores within the normal range and, consequently the data showed no issues of multicollinearity. With moderation models, the inclusion of an interaction term can lead to issues of multicollinearity between the interaction and the independent variables. In order to mitigate this, variables in the moderation analysis were centred as recommended by (Hayes, 2022).

Outliers

Firstly, standardised residuals and standardised predicted scatterplots were visually inspected to assess the presence of possible outliers. Scores of standardised residuals that were above 3 or below -3 were deemed to be of possible concern. No scores for any model exceeded either of these cut-offs and as such no scores were considered outliers from the initial visual inspection. However, for model 2 (self-compassion and personal self-care) two scores were identified as potential outliers given their positions on the plot and distance from other scores. Closer inspection of the two participants raw data indicated no concerns with responses or indication that these scores did not reflect genuine responses as such, the decision was made to not exclude these cases. To further assess the potential presence of outliers and consider the influence such scores may have, cut-off scores for Mahalanobis (using a conservative cut off of $p < .001$ for critical χ^2), Cooks distance and leverage statistics were calculated for each model. Dummy variables were created for each statistic based on cut-off scores where 0 = not an outlier and 1 = an outlier for that particular statistic. If a case was considered an outlier across all three statistics, then

that case deemed to be a true possible outlier. No cases exceeded the cut-off points on all three scores, and as such no outliers were deemed to be present.

Normality

Histograms, p-p plots of standardised residuals as well as scatterplots of standardised residual compared to standardised predicted values were examined to assess the assumption of normality. Model 1 (self-compassion and professional self-care) and model 2 (self-compassion and personal self-care) showed no concerns for normality with the histograms relatively normal and scores ranging between -3 to 3. The scatterplots also showed the majority of data spread randomly between -3 and 3 on both axes, appearing roughly rectangularly distributed with concentrated scores around 0. Similarly, the residuals followed closely along a straight line on the p-p plot. As such, no concerns were present for normality of models 1 and 2.

Model 3 (self-compassion, self-care and burnout) and model 4 (moderation) both showed slight positive skew in the histogram, although both histograms still appeared to follow a roughly normal distribution. The scatter plots for both model 3 and 4 showed no concerns with the data randomly distributed between -3 and 3 and scores concentrated around 0. The p-p plots for both showed some points further away from the line but all points still followed along a straight line. The slight positive skew seen in both histograms was not deemed a concern as regression analysis has been deemed robust against slight violations of normality (Field, 2018; Hayes, 2022). Further, the Central Limit Theorem (CLT) states that irrespective of a samples distribution, as sample size increases above $n \geq 30$, all distributions will increasingly approach a normal distribution (Tabachnick, 2019; Williams et al., 2013). Given the sample size for this present study of $n = 197$, the slight positive skew was deemed to be a minor violation and was not a cause for concern. Subsequently, data transformations were not deemed necessary.

Hierarchical Regression Analyses

Hierarchical multiple regression was conducted for each model investigating the ability of the independent variable (IV; self-compassion and/or self-care) to predict the dependent variable (DV; professional self-care, personal self-care, or burnout) in psychologists after controlling for the influence of relevant demographic factors. Preliminary analyses of the assumptions of multiple regression confirmed no violation of normality, linearity, multicollinearity or homoscedasticity of residuals.

Model 1: Self-compassion and Professional Self-Care

Model 1 investigated the ability of self-compassion to predict engagement in professional self-care after controlling for the influence of work setting and hours spent working in psychological practice per week as seen in Table 5. Control variables of work setting and dummy coded hours spent working in psychological practice per week were entered at step 1. The initial model with demographics was significant with 5% of the variance in professional self-care being explained by the control variables, $F(3,193) = 3.38, p = .02, R^2 = .05$. In model 1, when controlling for demographics, work setting was not a significant predictor of professional self-care ($\beta = -.14, t(193) = -1.92, p .06, sr^2 = -.02$). Hours spent in psychological practice was a significant predictor of professional self-care but only for those who worked more than 35 hours per week compared to those who worked 25 or less hours ($\beta = -.21, t(193) = -2.13, p .03, sr^2 = -.02$). When looking at those who worked 26 – 30 hours per week compared to those who worked 25 or less hours, this was not significant in predicting professional self-care engagement ($\beta = -.12, t(193) = -1.23, p .22, sr^2 = -.01$). As such, working more than 35 hours per week in psychological practice was found to individually explain 2% of the variance in professional self-care.

Self-compassion was added in step 2 and the model with self-compassion was also significant, $\Delta F(1,192) = 35.85, p < .001, \Delta R^2 = .15$. Thus, the change in F and the change in R^2 from the inclusion of self-compassion was significantly different. Adding self-compassion to the model explained an additional 15% of the variance in professional self-care above and beyond the demographic variables.

Consequently, self-compassion was a significant predictor of professional self-care ($\beta = .39$, $t(192) = 5.99$, $p < .001$, $sr^2 = .15$). The findings for self-compassion indicate that as self-compassion increases by one unit, psychologists' professional self-care increases by 2.79 units. The total variance in professional self-care explained by both demographics and self-compassion is 20%.

Table 5*Hierarchical Regression Analysis of Self-Compassion with Professional Self-Care*

	<i>Coeff (B)</i>	<i>Se (SE B)</i>	<i>Beta (β)</i>	<i>sr</i>	<i>R²</i>	<i>ΔR^2</i>
Step 1					.05	.05*
(Constant)	28.73**	1.27				
Work setting	-1.33	.69	-.14	-.14		
Hours (26 – 35)	-1.26	1.03	-.12	-.09		
Hours (over 35)	-2.05*	.96	-.21*	-.15		
Step 2					.20	.15**
(Constant)	18.16	2.12				
Work setting	-.88	.64	-.09	-.10		
Hours (26 – 35)	-1.03	.95	-.10	-.08		
Hours (over 35)	-1.70	.89	-.18	-.14		
Self-compassion	2.79**	.47	.39**	.41		

Note. *sr* is representative of semi partial correlation coefficient.

*Correlations significant at the $p < .005$ level. ** Correlations significant at the $p < .001$ level.

Model 2: Self-Compassion and Personal Self-Care

Model 2 investigated the ability of self-compassion to predict engagement in personal self-care after controlling for the influence of ethnicity, age, work setting, and years spent working in psychological practice as seen in Table 6. Dichotomous control variables of ethnicity and work setting, along with dummy coded control variables of age and years spent working in psychological practice, were entered

at step 1. The initial model with demographics was significant with 9% of the variance in personal self-care being explained by the control variables, $F(6,189) = 3.07, p = .001, R^2 = .09$. In model 2, none of the control variables were significant predictors of personal self-care with all $p > .05$.

Self-compassion was added in step 2 and the model with self-compassion was found to be significant, $\Delta F(1,188) = 48.05, p = <.001, \Delta R^2 = .19$. Thus, the change in F and the change in R^2 from the inclusion of self-compassion was significantly different. Adding self-compassion to the model explained an additional 19% of the variance in personal self-care above and beyond the demographic variables. Consequently, self-compassion was a significant predictor of personal self-care ($\beta = .47, t(188) = 6.93, p <.001, sr^2 = .19$). The findings for self-compassion indicate that psychologists' personal self-care increases by 4.19 units for every unit increase in self-compassion. The total variance in personal self-care explained by both demographics and self-compassion is 27%.

Table 6

Hierarchical Regression Analysis of Self-Compassion with Personal Self-Care

	<i>Coeff (B)</i>	<i>Se (SE B)</i>	<i>Beta (β)</i>	<i>sr</i>	R^2	ΔR^2
Step 1					.09	.09*
(Constant)	22.61**	2.63				
Work setting	-1.49	.90	-.12	-.12		
Ethnicity	1.73	.97	.13	.12		
Age (36 – 50)	-1.09	1.18	-.09	-.06		
Age (over 50)	1.52	1.60	.11	.07		
Practice Years (6 – 15)	.76	1.21	.06	.04		
Practice Years (over 15)	.95	1.51	.08	.04		
Step 2					.27	.19**
(Constant)	11.48**	2.85				
Work setting	-1.36	.80	-.11	-.11		
Ethnicity	.38	.89	.03	.03		

	<i>Coeff (B)</i>	<i>Se (SE B)</i>	<i>Beta (β)</i>	<i>sr</i>	<i>R²</i>	<i>ΔR^2</i>
Age (36 – 50)	-2.09	1.07	-.17	-.12		
Age (over 50)	-.27	1.46	-.02	-.01		
Practice Years (6 – 15)	.47	1.09	.04	.03		
Practice Years (over 15)	.51	1.35	.04	.02		
Self-compassion	4.19**	.60	.47**	.43		

Note. sr is representative of semi partial correlation coefficient.

*Correlations significant at the $p < .005$ level. ** Correlations significant at the $p < .001$ level.

Model 3: Self-Care and Self-Compassion and Burnout

Model 3 investigated the ability of self-care and self-compassion to each predict burnout in psychologists after controlling for the influence of age and years spent working in psychological practice as seen in Table 7. Dummy coded control variables of age and years spent working in psychological practice were entered at step 1. The initial model with demographics was significant with 8% of the variance in burnout being explained by the control variables, $F(4,191) = 4.26, p = <.01, R^2 = .08$.

In model 3, when controlling for demographics, years spent working in psychological practice was not a significant predictor of burnout ($\beta = .05, t(191) = .53, p .60$ and $\beta = .01, t(191) = .12, p .91$). Age was a significant predictor of burnout but only for those aged greater than 50 compared to those who were aged 35 or less ($\beta = -.33, t(191) = -2.83, p .005, sr^2 = -.04$). While those who were aged 36 – 50 compared to those who were aged 35 or less, hours was not significant in predicting burnout ($\beta = -.12, t(191) = -1.23, p .22, sr^2 = -.01$). As such, age greater than 50 was found to individually explain 4% of the variance in burnout.

Self-care was added in step 2 and the model with self-care was also significant, $\Delta F(1,190) = 37.49, p = <.001, \Delta R^2 = .15$. Thus, the change in F and the change in R^2 from the inclusion of self-care was significantly different. Adding self-care to the model explained an additional 15% of the variance in burnout above and beyond the demographic variables. Consequently, self-compassion was a significant

predictor of burnout ($\beta = -.40$, $t(190) = -6.12$, $p < .001$, $sr^2 = .15$). The findings for self-care indicate that for every one unit increase in self-care, psychologists' burnout decreases by .62 units. The total variance in burnout explained by both demographics and self-care is 23%. Self-compassion was added in step 3 and the model with self-compassion was also significant, $\Delta F(1,189) = 14.86$, $p = <.001$, $\Delta R^2 = .06$. Thus, the change in F and the change in R^2 from the inclusion of self-compassion was significantly different. Adding self-compassion to the model explained an additional 6% of the variance in burnout above and beyond the demographic variables and self-care. Consequently, self-compassion was a significant predictor of burnout ($\beta = -.29$, $t(189) = -3.85$, $p < .001$, $sr^2 = .06$). The findings for self-compassion indicate that for every one unit increase in self-compassion, psychologists' burnout decreases by 6.55 units. The total variance in professional self-care explained by both demographics and self-care is 29%.

Table 7*Hierarchical Regression Analysis of Self-Compassion and Self-care with Burnout*

	<i>Coeff (B)</i>	<i>Se (SE B)</i>	<i>Beta (β)</i>	<i>sr</i>	R^2	ΔR^2
Step 1					.08	.08*
(Constant)	46.91**	2.16				
Age (36 – 50)	-3.70	3.00	-.12	-.09		
Age (over 50)	-11.38*	4.02	-.33*	-.20		
Practice Years (6 - 15)	1.58	2.98	.04	.04		
Practice Years (over - 15)	.44	3.72	.01	.01		
Step 2					.23	.15**
(Constant)	76.93**	5.29				
Age (36 – 50)	-4.20	2.75	-.13	-.10		
Age (over 50)	-8.91*	3.70	-.26*	-.15		
Practice Years (6 - 15)	1.63	2.73	.05	.04		
Practice Years (over - 15)	.59	3.41	.02	.01		
Self-care	-.62**	.10	-.40**	-.39		

	<i>Coeff (B)</i>	<i>Se (SE B)</i>	<i>Beta (β)</i>	<i>sr</i>	<i>R²</i>	<i>ΔR^2</i>
Step 3					.29	.06**
(Constant)	87.47**	5.79				
Age (36 – 50)	-2.17	2.71	-.07	-.05		
Age (over 50)	-6.27	3.64	-.18	-.11		
Practice Years (6 - 15)	1.59	2.64	.05	.04		
Practice Years (over - 15)	.75	3.29	.02	.01		
Self-care	-.41**	.11	-.26**	-.23		
Self-compassion	-6.55**	1.70	-.29**	-.24		

Note. sr is representative of semi partial correlation coefficient.

*Correlations significant at the $p < .005$ level. ** Correlations significant at the $p < .001$ level.

Moderation analysis

Model 4: Self-Compassion as a Moderator of Self-Care and Burnout

The relationship between self-care, self-compassion and burnout was explored further using the simple moderation model (Model 1) found in Hayes (2022) PROCESS macro. Moderation explores the combined effect [or the interaction] of two or more independent variables on a specified dependent variable (Field, 2018). Specifically, moderation refers to the situation where the relationship between an independent variable and the dependent variable changes as a function of the moderator variable (Field, 2018). As such, a variable is said to be a moderator if it can change the direction, size or strength of an association between a predictor and an outcome variable (Field, 2018; Hayes, 2022). Figure 1 shows a simple conceptual representation of a moderation model. The diagram depicts a scenario where the effect of an independent variable (X) on a dependent variable (Y) is influenced by or is dependent on a third variable (W), where (W) is the moderator variable (Hayes, 2022). In the case of this research, the moderation analysis explored the relationship between self-care (X) and burnout (Y), in relation to the influence of self-compassion (W).

Figure 1

Visual Depiction of a Simple Moderation Model

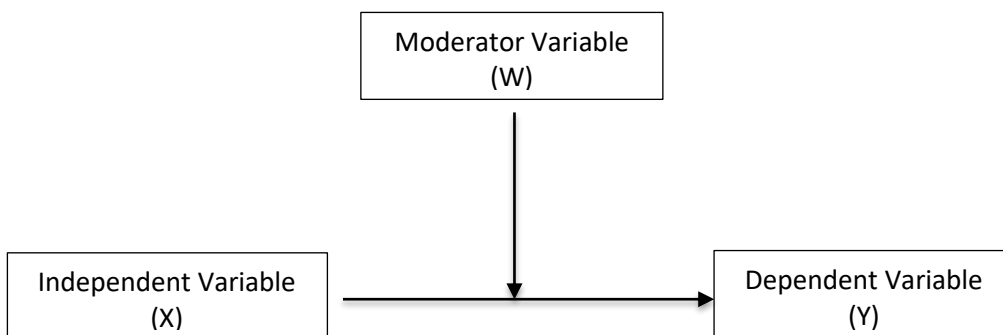
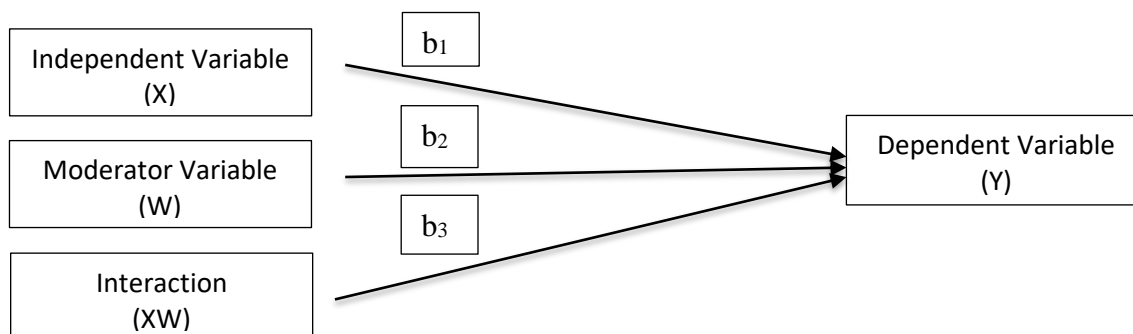


Figure 2 shows the statistical diagram of moderation, where moderation involves the effect of the independent variable (X), the moderator (W) and the interaction (XW) of the two on the dependent variable (Y).

Figure 2

Visual Representation of a Statistical Moderation Model



In the statistical moderation model, b_1 refers to the relationship between X (self-care) and Y (burnout) when W (self-compassion) = 0; b_2 refers to the relationship between W (self-compassion) and Y (burnout) when X (self-care) = 0; and b_3 represents the interaction effect of X (self-care) and W (self-compassion) on Y (burnout). Specifically, b_3 estimates the change in Y (burnout) for cases that differ by a unit on X (self-care) as W (self-compassion) changes by a unit (Hayes, 2022). To enable meaningful

interpretation of the moderation output, Hayes (2022) recommends mean centring predictors within the model. By centring the values, a score of 'zero' on the predictor refers to the mean for that variable such that b_1 and b_2 will now represent the effect of one independent variable when the other independent variable is equal to the mean (zero). Further, given independent variables are highly correlated with the added interaction term in moderation models, mean centring is important to remove any concerns with multicollinearity within the model (Field, 2018; Hayes, 2022). Consequently, the moderation analysis in this study was mean centred. Simple slopes analyses were used to determine the nature of the moderation effect. Simple slopes provide a model of the independent and dependent variables at low, average and high levels of the moderators where low = 1 SD below the mean, average = mean, and high = 1 SD above the mean (Field, 2018). Johnsons-Neyman was also conducted and used to calculate the zone of significant to determine values at which the influence of the moderator on the relationship between X and Y was significant (Field, 2018).

A moderation analysis was run to investigate self-compassion as a moderator of the relationship between self-care (independent variable) and burnout (dependent variable). The overall moderation model was significant; $F(7,188) = 11.97, p < .001, R^2 = .31$, with 31% of the variance in burnout being explained by the moderation model along with covariates. Table 8 displays the main effects of the moderation model. There was a significant main effect found between self-care and burnout ($b = -.47, t(188) = -4.13, p < .001$) indicating that as self-care engagement increases, burnout decreases. Self-compassion was also found to have a significant main effect on burnout ($b = -6.91, t(188) = -4.09, p < .001$) indicating that as the level of self-compassion increases, burnout decreases. There was also found to be a significant interaction of self-compassion on self-care and burnout ($b = -.32, t(188) = -2.29, p = .02$). In order to interpret the effect of the interaction, simple slope analysis was conducted. The significance of the main effects for self-care, self-compassion and the interaction are further confirmed by none of the confidence intervals containing zero. None of the covariates were significant in the

moderation model with all models having $p > .05$, indicating that there was no significant main effect of either age or practice years on burnout. Adding the interaction to the model resulted in a significant change, $F(7,188) = 5.24$, $p = .02$, $\Delta R^2 = .02$. Consequently, the interaction term contributed to explaining 2% of the variance in burnout.

Table 8

Linear Moderation Model of Predictors of Burnout

	<i>Coeff (B)</i>	<i>Se (SE B)</i>	<i>t</i>	<i>P</i>	LLCI	ULCI
Constant	44.99	1.9	23.18	< .001	41.16	48.82
Self-care (centered)	-.47	.11	-4.13	< .001	-.70	-.25
Self-compassion (centred)	-6.91	1.69	-4.09	< .001	-10.24	-3.58
Self-care x Self- compassion	-.32	.14	-2.29	.02	-.59	-.04
Age DC2	-1.93	2.68	-.72	.47	-7.21	3.36
Age DC3	-4.82	3.65	-1.32	.19	-12.03	2.38
Prac Years DC2	2.12	2.62	.81	.42	-3.05	7.30
Prac Years DC3	1.11	3.26	.34	.73	-5.32	7.54

Note. Age DC2 (36 – 50 years old), Age DC3 (Over 50 years old), Prac Years DC2 (6 – 15 years in psychological practice), Prac Years DC3 (over 15 years in psychological practice). LLCI (Lower Limit Confidence Interval) and ULCI (Upper Limit Confidence Interval). $R^2 = .31$

The results of the simple slopes analysis can be seen in Table 9. For individuals who reported higher than average self-compassion, there was a greater effect of self-care on burnout when compared to average or below average levels. For low self-compassion (1 SD below the mean) the effect was not significant ($b = -.26$, $t(188) = -1.96$, $p > .05$), indicating that for those low in self-compassion, self-care does not predict burnout. For average (mean) self-compassion the effect was significant ($b = -.47$, $t(188)$

= -4.13, $p < .001$) indicating that for average self-compassion, self-care is a negative predictor of burnout. Specifically, for those with mean levels of self-compassion, as self-care engagement increases, burnout decreases. For high self-compassion (1 SD above the mean) the effect was significant ($b = -.69$, $t(188) = -4.19$, $p < .001$) indicating that for high self-compassion, self-care negatively predicts burnout. Specifically, for those with high levels of self-compassion, as self-care engagement increases, burnout decreases. Overall, these findings indicate that as self-care increases in conjunction with higher self-compassion, the impact of self-care on burnout is more negative.

The strongest relationship (greatest effect size) is seen for individuals who have self-compassion levels 1 SD above the mean, where the negative impact of self-care on burnout is stronger. The effect size for simple slopes analysis indicates that for a specific level of W (self-compassion), for every unit increase on X (self-care) an individual's score on Y (burnout) is impacted by this amount. Consequently, for high self-compassion (scores ≥ 4.12) every unit increase of self-care results in a .69 unit decrease in burnout levels. For individuals with average self-compassion (scores of 3.44) each unit increase of self-care results in a .47 decrease in burnout levels. The moderating relationship of self-compassion on self-care and burnout was not found to be significant for individuals with low self-compassion (scores ≤ 2.76). This indicated that low scores on self-compassion does not have an impact, but once the scores reach the mean or above, there is a significant negative impact on burnout. As self-compassion and self-care increase, they lead to an increased negative impact of burnout. Consequently, from these results self-compassion can be determined to be a significant moderator of the relationship between self-care and burnout in psychologists.

Table 9

Simple Slope Analyses for Moderation Model

	<i>Effect</i>	<i>Se</i>	<i>t</i>	<i>P</i>	<i>LLCI</i>	<i>ULCI</i>
Low Self-Compassion (-.68)	-.26	.13	-1.96	.05	-.51	.00

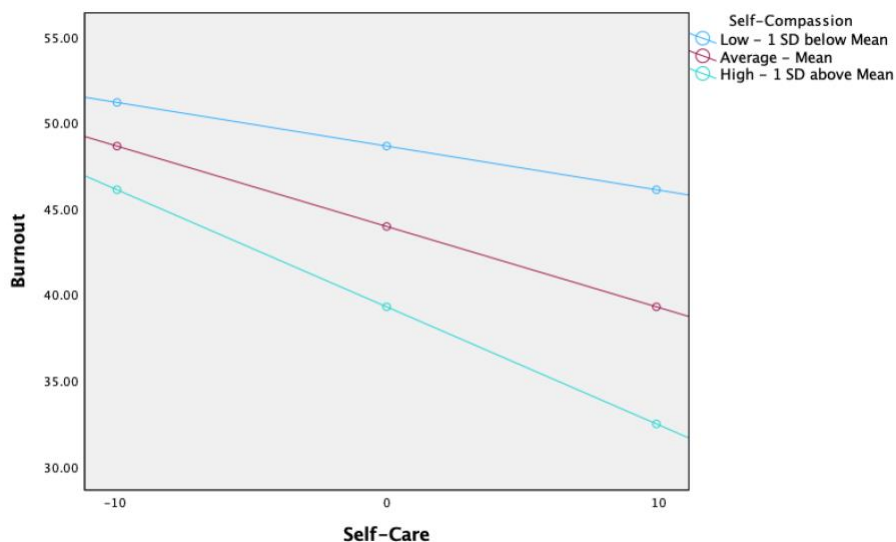
	<i>Effect</i>	<i>Se</i>	<i>t</i>	<i>P</i>	LLCI	ULCI
Average Self-Compassion (0)	-.47	.11	-4.13	< .001	-.70	-.25
High Self-Compassion (.68)	-.69	.16	-4.19	< .001	-1.01	-.36

Note. -.68 is 1 SD below the mean, 0 is the centred mean and .68 is 1 SD above the mean. LLCI refers to Lower Limit Confidence Interval and ULCI refers to Upper Limit Confidence Interval.

Inspecting Johnson-Neyman for the zones of significance showed that at $p = .05$ significance level, the interaction between self-compassion and self-care on burnout becomes significant at .67 below the mean and higher. For individuals scoring 2.77 on self-compassion and higher, the interaction between self-compassion and self-care on burnout is significant. Examination of the interaction plot (figure 3) shows that the association between self-care and burnout, becomes stronger as self-compassion levels increase. When levels of self-compassion are low there is a non-significant, negative relationship between self-care and burnout. At average (mean) levels of self-compassion, there is a significant negative relationship between self-care and burnout. The negative relationship between self-care and burnout becomes even stronger at high levels of self-compassion.

Figure 3

Interaction Plot of Self-compassion's Influence on the Relationship Between Self-Care and Burnout



Chapter 5: Discussion

The aim of this study was to explore the relationship between self-compassion and self-care practices within New Zealand and Australian psychologists ($n = 197$). A further aim of this research was to investigate the link between self-compassion, self-care and burnout. Specifically, the study aimed to determine whether self-compassion may strengthen the relationship between self-care and burnout in New Zealand and Australian psychologists. An additional aim of this study was to determine how Zealand and Australian psychologists fare in terms of self-care, self-compassion and burnout more generally, given the lack of current data within this population. Two hierarchical regression analyses were conducted to explore self-compassion's relationship with both personal and professional self-care. A third hierarchical regression analysis was run to examine the association between both self-care and self-compassion with burnout. A final moderation analysis was run with self-care as the independent variable (X), burnout as the dependent variable (Y) and self-compassion as the moderator variable (W) to determine whether self-compassion significantly moderated the relationship between self-care and burnout.

All hypotheses were supported by the results of this research. Specifically, self-compassion was positively associated with psychologists' engagement in personal self-care (1) and professional self-care (2). Psychologists' level of self-care engagement and level of self-compassion was negatively associated with burnout (3). Finally, psychologists' level of self-compassion was found to strengthen the relationship between self-care and burnout (4). Results also showed that, in line with claims within the existing literature, psychologists fared only averagely in terms of engagement in self-care practices. Similarly, New Zealand and Australian psychologists were found to have moderate levels of self-compassion and burnout. The ensuing discussion will provide further exploration and context for these findings along with possible implications respect to the current evidence base and original research.

Following this review, the methodological strengths and weaknesses of this research along with recommendations for future research will be discussed.

Psychologists Level of Self-compassion, Self-care and Burnout

Self-Compassion

The sample of New Zealand and Australian psychologists in this research had moderate levels of self-compassion, with a mean score of 3.4. The mean self-compassion score found in this research is similar to that of prior research on American social workers (Lianekhammy et al., 2018; Miller et al., 2019; Miller et al., 2020) and healthcare professionals (Hashem & Zeinoun, 2020) but higher compared to prior research on Irish social work students (Kotera, Tsuda-McCaie, et al., 2021). Thus, New Zealand and Australian psychologists score similarly to other mental health professionals in terms of self-compassion. However given the lack of previous research, these findings offer initial estimates of self-compassion levels within New Zealand and Australian psychologists. The moderate level of self-compassion found in this study indicates there is still substantial room for improvement for psychologists in terms of being compassionate towards themselves. Given the many documented benefits of self-compassion, it may be beneficial for future research to continue to explore self-compassion within this population, particularly with regards to intervention studies aimed at increasing self-compassion levels.

Self-Care

The results of this research found that psychologists engaged in self-care only moderately, with the lowest engagement found for personal self-care practices. The average level of overall self-care was 49.1 out of 72, with an average score of 25.2 and 23.8 out of 36 for professional and personal self-care respectively. This moderate engagement in self-care is in line with qualitative concerns in the literature that psychologists tend to be poor at prioritising their own wellbeing (Coleman et al., 2016; Norcross & VandenBos, 2018) and tend to overlook their own self-care (Dattilio, 2015). Given the crucial need for

psychologists to engage in effective self-care for their own welfare and the ethical imperative for competent practice (Barnett et al., 2007; Posluns & Gall, 2020), these results highlight psychologists' capacity for improvement in self-care and the need to investigate factors that may increase self-care engagement within psychologists. These results are among the first to provide quantitative support for these points and offers initial estimates of self-care within a New Zealand and Australian population of psychologists.

Burnout

The mean scores for burnout found in this study for all burnout subscales, as well as overall burnout, were higher than those seen in prior research on Australian psychologists (D'Souza et al., 2011; Di Benedetto & Swadling, 2014), American mental health graduates and professionals (Warlick et al., 2021), and Danish human service workers (Kristensen et al., 2005). Specifically, this research found 29.4% of psychologists met the criteria for burnout compared to 14.4% and 8% of Australian psychologists who met the criteria for burnout in studies by Di Benedetto and Swadling (2014) and D'Souza et al. (2011) respectively. The results of this study appear more similar to a recent study on Australian psychologists by (McCade et al., 2021) that found 27.8% of psychologists sampled met the criteria for burnout. These results indicate a real, significant risk of burnout within New Zealand and Australian psychologists, perhaps even suggesting that the risk of burnout for psychologists may be increasing given the findings of this study and McCade et al. (2021) compared to earlier findings on Australian psychologists (D'Souza et al., 2011; Di Benedetto & Swadling, 2014). These increased rates are a concern; given the higher rates are post-Covid, when mental distress and the strain on mental health services increased, it could represent a profession that is straining under increased demand. It is important to acknowledge, however, that the higher levels could also be due to differences in sample characteristics between this study and prior research. Nevertheless, the high risk of burnout seen in this

research highlights the importance for future studies to build upon these initial findings and continue to explore protective factors and practices for the psychology profession.

These findings contribute to the burnout, self-compassion and self-care literature by offering initial estimates of each factor within a New Zealand population of psychologists, which is important given the relative paucity of research on psychologists in general but specifically within a New Zealand context.

Self-Compassion's Relationship with Professional and Personal Self-Care

The results confirmed that there was a significant positive relationship between psychologists' level of self-compassion and their engagement in professional and personal self-care behaviours. This suggests that New Zealand and Australian psychologists high in self-compassion are more likely to engage in an increased number of both professional and personal self-care behaviours. This finding is consistent the general health activation research that suggests self-compassion promotes positive engagement in health behaviours such as physical exercise, sleep and healthy eating (Colman et al., 2016; Sanchez-Reilly et al., 2013; Sirois et al., 2015) as well as engagement in health management behaviours for individual wellbeing (Ferrari et al., 2017; Homan & Sirois, 2017).

Additionally, these findings are in line with the two existing studies to examine self-compassion's relationship with self-care (Miller et al., 2019; Mills et al., 2018). These results replicate the findings of the only other known study to directly investigate the link between self-compassion and professional and personal self-care in mental health professionals (Miller et al., 2019). Miller et al. (2019) also reported that self-compassion was significant predictor of professional and personal self-care in social workers over and above significant covariates, with self-compassion explaining an additional 14.3% and 14.2% of the variance in professional self-care and personal self-care respectively (Miller et al., 2019). Comparatively, this study found self-compassion to significantly predict psychologists' engagement in both professional and personal self-care, with self-compassion explaining

an additional 15% and 19% of the variation in professional self-care and personal self-care practices respectively over and above relevant covariates. Interestingly, self-compassion was found to explain a greater amount of variance in personal self-care compared to professional self-care within this research; although professional and personal self-care engagement were not compared directly, these results open the pathway for future research to build on and expand these initial findings. It could be that professional self-care is considered 'a part of the job' as per ethical codes of practice for psychologists, while the professional requirement for personal self-care is often not realised.

Although this study did not investigate mechanisms that may be involved in understanding how or why self-compassion is associated with greater self-care (and neither has any prior research explicitly investigated this), speculation can be seen within the wider literature. For example, self-compassion may lead to greater engagement in self-care practices due to its association with promoting motivation and positive [health] action (Neff, 2023a; Norcross & VandenBos, 2018), improving recognition of one's own needs (Colman et al., 2016; Pakenham, 2017), reducing feelings of stigma and shame (Norcross & VandenBos, 2018), and/or being accepting of taking time for oneself (Dattilio, 2015; Neff, 2023a; Norcross & VandenBos, 2018). Greater self-compassion for psychologists may lead to increased awareness of when they are struggling and enable them to be more accepting of asking for help and taking time for themselves without feeling selfish or concerned about stigma (Colman et al., 2016; Neff, 2023a; Norcross & VandenBos, 2018; Pakenham, 2017). However, these are all still speculative as research has not currently explored these theories and more research is required.

The finding that self-compassion is associated with greater engagement in personal and professional self-care practices within psychologists offers an important contribution to the developing [self-care] literature by verifying self-compassion's association with self-care (Miller et al., 2019; Mills et al., 2018) and extending these findings for the first time to psychologists and within a New Zealand and

Australian context. Building on the limited literature base investigating self-compassion's relationship with self-care is important to corroborate and expand on current findings.

Further, investigating this link within psychologists is valuable given the ethical imperative of self-care for psychologists alongside the moderate levels of self-care found within this population. The finding that self-compassion increases psychologists' personal and professional self-care offers considerable utility for the profession especially given that self-compassion can be taught and increase through interventions. Further exploration of self-compassion as a target factor for improving psychologists' self-care (through intervention studies teaching self-compassion) would be beneficial to confirm its utility and determine the applicability of self-compassion as a method to promote self-care for psychologists.

Due to the cross-sectional nature of this study, it is important to acknowledge that these results are correlational and therefore causation cannot be inferred. Consequently, longitudinal research is needed to add to the literature base and offer potential evidence for a causal relationship between the two factors. Further, given the current scarcity of research specifically investigating the link between self-compassion and self-care practices, these results are more exploratory by nature and additional research is needed to clarify and confirm the relationship between self-compassion and self-care within psychologists. Despite this, these results highlight self-compassion as a promising factor for boosting engagement in self-care practices of psychologists in New Zealand and Australia.

Self-Compassion, Self-Care and Burnout

The results confirmed that there was a significant negative relationship between psychologists' level of self-compassion and their level of burnout. They also confirmed that there was a significant negative relationship between psychologists' level of engagement in self-care and their level of burnout. The negative association between both self-compassion and self-care with burnout found in this research is consistent with a personal resources approach to buffering burnout in line with JD-R and COR

models. Self-compassion and self-care can be viewed as internal, personal resources that an individual can use to help mitigate the impact stressors and buffer deleterious consequences such as burnout.

Self-care was found to uniquely explain 15% of the variation in psychologist's burnout level, highlighting that greater engagement in self-care is associated with a lower level of burnout in psychologists. As previously mentioned, direct comparison between studies investigating self-care and burnout is difficult given the wide variation in self-care measurements and theory utilised. Despite this, the relationship between self-care and burnout found in this research is in line with the prior research on mental health professionals. For example, self-care in the form of career sustaining behaviour has been found to be associated with less burnout in Australian psychologists (Di Benedetto & Swadling, 2014) and counsellors (Earle, 2017). Similarly, self-care as measured across core domains involving physical, spiritual, emotional, psychological and professional self-care has been linked to lower burnout and compassion fatigue in hospice workers (Alkema et al., 2008) and lower emotional exhaustion in psychologists (Rupert & Dorociak, 2019).

In this study, self-compassion explained an additional 6% of the variation in burnout over and above self-care, with higher self-compassion resulting in lower levels of burnout in psychologists. The relationship between self-compassion and burnout found in this study is consistent with prior research that has investigated these factors in various helping professions. Specifically, greater self-compassion has been linked with lower burnout in psychologists (Eriksson et al., 2018), student counsellors and behavioural psychotherapists (Beaumont et al., 2016). A study on Australian psychologists relatedly found that increased self-compassion is associated with reduced stress symptoms (Finlay-Jones et al., 2015).

In summary, the results of this research indicate that psychologists who have higher self-compassion tend to experience lower levels of burnout and similarly, psychologists who have greater engagement in self-care tend to experience lower levels of burnout. These findings provide initial

evidence for self-compassion and self-care being key personal resources for psychologists to focus on accumulating to protect against burnout.

This research contributes to our understanding of burnout's relationship with self-compassion and self-care in several ways. Firstly, this research builds on the limited literature confirming self-care's link with burnout among Australian psychologists and provides initial, novel evidence for this relationship in New Zealand psychologists. Most importantly it verifies the association not only in an understudied population, but it also utilises a theoretically robust conceptualisation and measure of self-care, supporting future researchers to start systematically investigating the impact of self-care and enabling the direct comparison of future findings. Regarding self-compassion, the results of this study extend prior research findings investigating the link between self-compassion and burnout for the first time to New Zealand and Australian psychologists. These findings also offer a much-needed addition to the comparatively lacking personal resource research within the burnout literature (Siebert, 2005; Yang & Hayes, 2020), enabling exploration of a resource (Neff & Germer, 2013) that may be beneficial in reducing burnout in psychologists.

Although causality cannot be inferred from this research due to the cross-sectional design' of the study, the results provide valuable information for psychologists and the psychology profession. They indicate for the first time the benefit of self-compassion for psychologists with regards to burnout and they also provide much needed empirical evidence to support the argument for the protective role of self-care against burnout. They also provide additional support for the ethical imperative of self-care engagement for psychologists through its link with reducing burnout given the heightened risk of stress for this population. Additional research is required to build upon these initial findings as given the dearth of current robust empirical research, the results of this research are best viewed as exploratory.

Self-Compassion as a Moderator

A core finding from this research was that self-compassion played a significant moderating role in the relationship between self-care and burnout. The results showed that for psychologists who reported average or higher than average self-compassion, the relationship between self-care and burnout was stronger such that the influence of self-care on burnout was more negative. In other words, psychologists who have greater engagement in self-care combined with higher self-compassion experience significantly lower levels of burnout.

The significant moderating effect of self-compassion, which strengthens the negative association that self-care has with burnout in psychologists, is a novel finding and there is no directly comparable research. It does however align with the general research that self-compassion is associated with self-care (Miller et al., 2019; Mills et al., 2018) and improving individuals' motivation towards, and engagement in, health promoting activities (Homan & Sirois, 2017; Neff, 2023a), as well as with the evidence that self-compassion improves resilience against stress related outcomes (Allen & Leary, 2010; Kotera, Cockerill, et al., 2021; Kotera, Tsuda-McCaie, et al., 2021).

Given the unique nature of this research and the constraints of the investigation, these findings are not able to provide clarity as to potential reasons for the moderating effect of self-compassion. Despite this, based off current literature and theoretical rationale, possible explanations for this effect could be hypothesised. One potential explanation could be that psychologists who have greater levels of self-compassion can have a greater awareness and recognition of their own needs along with a genuine desire and motivation to be kind towards oneself and take time to prioritise their needs (Colman et al., 2016; Neff, 2023a). This may result in them being more likely to take active steps towards engaging in self-care behaviours, which in turn serve to buffer against deleterious outcomes such as burnout. It is also possible that psychologists' self-compassion may play an important role in reducing barriers to self-care engagement which are prevalent in this population. For example, psychologists' tendencies to put

others' needs ahead of one's own needs (Norcross & VandenBos, 2018). Alternatively, self-compassion may serve to reduce the stigma associated with help seeking (Smith & Moss, 2009) along with the notion of self-care for the therapist as selfish (Norcross & VandenBos, 2018) or in some way a reflection of failure or professional incompetence (Dattilio, 2015). Overall, the significant moderation result found in this research is in line with the aforementioned empirical evidence and theoretical rationale linking self-compassion with self-care and self-compassion with burnout.

Interestingly, the moderating effect of self-compassion was only found for psychologists who scored average or above average on self-compassion, and not for psychologists who scored below average. This indicates that a psychologist's level of self-compassion does not have an impact at low scores, but it does play a significant role once scores reach the mean or higher. It is possible that the positive dimension of self-compassion (self-kindness, mindfulness and common humanity) rather than the negative dimension (self-judgment, over-identification and isolation) is influential in impacting self-care and reducing burnout. Nevertheless, the significant versus non-significant moderation finding for self-compassion provides an interesting direction for future research to consider why this difference may occur and whether the two dimensions of self-compassion play any role in these relationships. It is important to recognise that the moderation interaction term in this research accounted for only 2% of the variance in burnout, thus indicating that other factors in addition to self-compassion are likely to influence the relationship between self-care and burnout. As such, future research should also investigate other variables which may help us better understand the relationship between self-care and burnout in psychologists.

Given the exploratory nature of this research, the moderation findings are best viewed as tentative, offering purely correlational evidence to support this relationship rather than causal. Despite this, the current research offers a valuable contribution to the literature as it is the first known attempt at investigating and confirming the existence of the significant moderating role of self-compassion in the

relationship between self-care and burnout. This initial evidence sets the groundwork and highlights self-compassion as a promising factor for future research.

This research offers beneficial implications for psychologists, and the profession as a whole, as these findings indicate that the impact of self-care on burnout for psychologists is stronger when those psychologists also have average or higher levels of self-compassion. This highlights a target factor that both individual psychologists and the profession could focus on to improve the positive effects of self-care practices and thus further reduce the risk of burnout within such an inherently stressful profession. The utility of self-compassion as a target factor for future research is further highlighted by the fact that the results of this study also show self-compassion to be independently linked to improved self-care behaviours and reduced burnout within psychologists.

Additionally, the finding that self-compassion is a significant moderator of the relationship between self-care and burnout has important implications given that 29.4% of psychologists met the criteria for burnout within this study. The risk of burnout within psychologists appears very real and the finding that a modifiable, personal factor such as self-compassion may serve to both enhance self-care and strengthen its negative association with burnout offers much needed guidance for potential ways to both improve self-care practices and reduce negative stress outcomes within psychologists.

Summary

The findings highlight self-compassion as a promising target factor for enhancing self-care practices and ameliorating burnout in psychologists. This also emphasises the multifaceted utility of self-compassion in both enhancing positive outcomes and decreasing negative outcomes. Further, this research highlighted for the first time the potential moderating role of self-compassion between self-care and burnout. Consequently, this study offers initial evidence for self-compassion as a possible single factor which psychologists could focus on to lead to both better self-care and reduce their risk of burnout and it paves the way for future research to expand these tentative findings.

The focus on personal resources in relation to burnout in this research, rather than occupational factors, is beneficial given the scarcity of current personal resource literature. Personal resource research is particularly valuable given the current context and state of the psychology profession post-covid. Within Australia and New Zealand there are no quick organisational or systemic fixes for the increasing demand for psychological support; this, alongside the innate occupational stressors faced by psychologists, means psychologists need to look at ways they can protect themselves effectively against burnout whilst waiting for much needed systemic organisational change.

Strengths and Weaknesses

It is necessary to consider both the strengths and limitations of this study to appropriately quantify and interpret the findings. One major strength of this research was the use of a validated and replicable measure of self-care (SCPS) that was specifically designed for use within helping professionals. The use of a validated self-care measure is valuable given the lack of clarity and empirically driven research within the self-care literature base (Callan et al., 2021; Dorociak, Rupert, Bryant, et al., 2017). The use of a validated measure enables a more robust indication of the relationship between self-care and self-compassion within psychologists and improves the ability for additional research to replicate, compare and contrast findings. A further strength was the use of the CBI rather than the oversaturated and criticised MBI (Kristensen et al., 2005; Schaufeli, 2003). Utilising the CBI instead of MBI enabled examination of the core component of burnout (emotional exhaustion) without conflating burnout with a consequence (reduced personal accomplishment) or a coping strategy (depersonalisation) (Kristensen et al., 2005; Schaufeli & Taris, 2005).

Despite these strengths, several limitations need to be highlighted. Firstly, given the cross-sectional nature of this study, it is impossible to establish the temporal order or direction of relationships; nor whether a third, untested variable underlies these relationships (Homan, 2016; Rohrer et al., 2022). Consequently, causal inferences are not possible, and the results should be considered as

correlational evidence regarding the relationship between self-compassion and self-care as well as between self-compassion, self-care and burnout.

Utilising the Self-Compassion Scale - Short Form (Neff, 2003a), although beneficial for reducing survey fatigue, is limited in its ability to facilitate further analyses on how self-compassion moderates the relationship between self-care and burnout. This is particularly relevant with regards to the significant moderation for mean and high levels of self-compassion but not for low levels of self-compassion. The use of the short form does not enable investigation of whether the influence of self-compassion could be ascribed to its positive (self-kindness, mindfulness, common humanity) or negative (self-judgement, over-identification, isolation) dimensions (Neff & Tóth-Király, 2022).

Another limitation of this study is the use of self-report measures. Although aiding accessibility for participants, self-report measures are commonly subject to limitations such as response biases (Bucher et al., 2020). Specifically, self-report measures rely on participants having the capacity to accurately identify and acknowledge their own thoughts, feelings and behaviours, something that psychologists have been found to be poor, specifically in recognising their personal red flags or early indicators of burnout (Smith & Moss, 2009). Consequently, these results may not be representative of the true burnout levels within this population. Additionally, highly distressed psychologists experiencing burnout could have already left the profession and given the inclusion criteria for this study, would not have been captured. Further, the voluntary nature of the study could be considered a limitation with respect to investigating the variables of interest, in particular burnout. It is possible that participants who were more likely to respond to a survey of their own volition may be less likely to endorse higher levels of burnout than the wider population of interest.

Additionally, given the majority of responses came from New Zealand psychologists with only 9 from Australian psychologists, the results of this research are more representative of New Zealand psychologists than Australian psychologists. Furthermore, given the relatively homogenous nature of the

sample, generalisation of these findings to all New Zealand psychologists is limited. The participants were mainly Pākehā/New Zealand European, working over 31 hours per week, working in private or government/health funded practice, and working as a clinical psychologist. As such, any attempts to generalise these findings beyond the sample characteristics of this research needs to be done with caution.

Future Research and Recommendations

The results of this research, along with the previously mentioned limitations, highlight several avenues and considerations for future research. Notably, given the underdeveloped nature of this body of literature it would be beneficial for research to continue to confirm these relationships both within psychologists and other mental health populations. This is especially the case for the moderating role of self-compassion which until now has not been investigated with respect to self-care and burnout.

Additionally, considering the moderate levels of self-care found in psychologists in this research (along with the ethical imperative of self-care), there is a clear need for future research to continue to explore and investigate factors that may boost self-care practices within this population. Self-compassion offers a promising first step in research aimed at improving self-care for psychologists, but additional studies are needed that focus on both self-compassion as well as other relevant factors to develop a rich literature base. The need to explore other factors is also reinforced by the fact that the interaction term within the moderation model only accounted for 2% of the variance in burnout, highlighting that other factors likely play a role in understanding these relationships.

Given these findings and the exploratory nature of the research base, it would be beneficial for additional studies to incorporate a qualitative component to help better understand psychologists' engagement in, and barriers to, self-care as well as any potential additional factors that may be relevant in the relationships between self-care, self-compassion and burnout. Qualitative research would enable

greater exploration of relevant themes and concepts to aid future research to build upon these initial findings.

Further, given the research is cross-sectional, it would be beneficial for future research to establish casual evidence for the relationship between self-compassion and self-care, as well as with regards to the moderating role of self-compassion with self-care and burnout. Research that utilises longitudinal design or randomised control interventions would enable more clarity around the temporal order of these relationships and thus, facilitate a more robust casual inference. Given the existence of Mindful Self-Compassion training (Germer & Neff, 2019) and potential benefit self-compassion may have in bolstering both self-care engagement and buffering burnout, intervention research would be especially useful. Intervention research would aid in determining the practical utility of self-compassion for psychologists beyond these initial findings. By understanding more about self-compassion's role, and the ability for self-compassion to be increased in psychologists, more specific strategies could be incorporated into psychologist professional development activities that focus on training self-compassion.

Additionally, the significant versus non-significant moderation finding for self-compassion provides a promising direction for further investigation to consider why this difference may occur and whether the two dimensions (positive and negative) of self-compassion play any role in these relationships. Consequently, to aid in the understanding of how self-compassion influences self-care and burnout, it would be interesting for future research to utilise the full self-compassion scale. The full scale would enable exploration of any differences or nuances in findings between the positive and negative dimensions of self-compassion (Neff, 2003a; Neff & Tóth-Király, 2022). An additional consideration for future research would be to provide a clear definition of self-care and utilise validated, empirical self-care measures. This would enable a systematic exploration of self-care, allow for a more direct comparison between studies and add empirical vigour to the literature base.

The sample in this research was predominantly New Zealand European, clinical psychologists. As such a more representative sample of psychologists in future research would enhance the generalisability of these findings to psychologists across New Zealand and Australia. It is also important to note that it was difficult to recruit psychologists for this study. It is possible that psychologists were too busy to contribute to research that directly benefits them and their wellbeing.

Ultimately, given the infancy of the literature surrounding self-compassion as a predictor of self-care (as well as self-compassion as a moderator), there is a call for additional research that provides further proof of concept for these results. Consequently, any future research that attempts to build up or replicate these relationships and enhance our understanding of self-compassion's role with self-care and burnout is recommended.

Chapter 6: Conclusion

The demanding nature of psychologists' work puts them at heightened risk of experiencing burnout. Self-care has been widely purported as an important protective resource against burnout, yet despite its importance, psychologists' engagement in self-care is generally lacking. Self-compassion is a promising factor for enhancing self-care and buffering burnout in psychologists. Thus, an initial aim of this study was to explore self-compassion's relationship with self-care in New Zealand and Australian psychologists (n = 197). Despite the importance of self-care for psychologists, and the heightened risk of burnout within this population, surprisingly few studies have systematically investigated factors that may be protective against burnout for this population. Consequently, a core aim of this research was to examine the relationships between self-compassion, self-care and burnout collectively. Specifically, this research aimed to investigate whether self-compassion was a factor by which the relationship between self-care and burnout in New Zealand and Australian psychologists could be strengthened.

Prior research has provided evidence to support self-compassion's role in promoting self-care in helping professionals; however, this evidence is exploratory in nature and in need of support. To date, no research has explored self-compassion as a potential moderator between self-care and burnout with most prior research on burnout in psychologists focusing almost exclusively on occupational causes rather than protective factors (Schaufeli, Bakker, et al., 2009). Therefore, this research conducted three hierarchical regression analyses along with a cross-sectional moderation analysis to provide initial evidence in support of potential personal resources to protect against burnout and boost self-care practices in New Zealand and Australian psychologists.

The results showed self-compassion to have a significant, positive relationship with psychologists' engagement in both personal and professional self-care. Further, self-compassion and self-care both had a significant, negative association with burnout. Finally, self-compassion was a significant moderator of the relationship between self-care and burnout, such that, self-compassion

strengthened the negative relationship that self-care had with burnout. This research provides much needed empirical support for personal factors that can buffer burnout in psychologists. These findings provide initial groundwork for exploring the moderating role of self-compassion and highlights new ways of thinking about self-compassion, self-care, and burnout within this population. The results of this research suggest that self-compassion is a means by which psychologists' engagement in both personal and professional self-care can be improved, and provides support for both self-compassion and self-care being factors that can reduce the risk of burnout in this population. Furthermore, they suggest that self-compassion could play a key role in strengthening the relationship that self-care has with burnout.

These initial findings contribute to the literature in numerous ways. This research is one of the first attempts to replicate Miller et al. (2019) initial study on self-compassion and self-care in social workers and thus, builds on the initial evidence showing that self-compassion is positively associated with self-care, confirming that these results are consistent within a population of New Zealand and Australian psychologists. Secondly, this research provides much needed empirical support for the role of self-care and self-compassion in buffering burnout. Adding empirical support to the burnout literature for psychologists is important as so far research has focused predominantly on healthcare populations such as doctors and nurses or other mental health occupations such as social workers. The risk of burnout in psychologists, alongside the current mental health landscapes in New Zealand and Australia further highlight the need for research to focus on personal factors that may be protective for psychologists. Further, the focus on protective personal resources in this research addresses a gap in the burnout literature for psychologists and highlights avenues for future research to continue to develop upon these results.

Finally, this research is the first known study to demonstrate the potential moderating role that self-compassion plays in the relationship between self-care and burnout. This offers a novel finding and paves the pathway for additional studies to focus on self-compassion as a core factor to focus on for

improving overall self-care engagement and ameliorating burnout in psychologists. Overall, this research provides initial proof of concept for self-compassion being predictive of self-care as well as self-compassion being a moderator, and it builds the foundation for considering more effective ways to protect against burnout.

These findings are of interest to psychologists and the psychology profession as a whole, as they provide support for a key factor that is easily trainable and can both improve self-care and reduce burnout within the occupation. The value of these findings is heightened given the current pressures facing psychologists and increase demands for services within New Zealand and Australia. Future research should continue to build on these findings to verify self-compassions utility as a personal resource for psychologists, and to substantiate the moderating role that self-compassion may play between self-care and burnout within this population as well as other mental health populations.

In summary, this research provides the groundwork for exploring self-compassion as a potentially beneficial resource for New Zealand and Australian psychologists. It offers a first step for clarifying the relationship between burnout and self-care with regards to self-compassion, and it provides recommendations for considering these relationships in future research.

References

- Abdollahi, A., Taheri, A., & Allen, K. A. (2020). Self-compassion moderates the perceived stress and self-care behaviors link in women with breast cancer. *Psycho-oncology*, 29(5), 927-933.
<https://doi.org/10.1002/pon.5369>
- Acker, G. M. (2012). Burnout among mental health care providers. *Journal of Social Work*, 12(5), 475-490. <https://doi.org/https://doi.org/10.1177/1468017310392418>
- Ackerley, G. D., Burnell, J., Holder, D. C., & Kurdek, L. A. (1988). Burnout among licensed psychologists. *Professional Psychology: Research and Practice*, 19(6), 624-631.
<https://doi.org/https://doi.org/10.1037/0735-7028.19.6.624>
- Alkema, K., Linton, J. M., & Davies, R. (2008). A study of the relationship between self-care, compassion satisfaction, compassion fatigue, and burnout among hospice professionals. *Journal of Social Work in End-of-Life & Palliative Care*, 4(2), 101-119.
<https://doi.org/10.1080/15524250802353934>
- Allen, A. B., & Leary, M. R. (2010). Self-Compassion, Stress, and Coping. *Social and Personality Psychology Compass*, 4(2), 107-118. <https://doi.org/10.1111/j.1751-9004.2009.00246.x>
- Australian Psychological Society. (2007). *APS Code of Ethics*.
<https://psychology.org.au/getmedia/d873e0db-7490-46de-bb57-c31bb1553025/18aps-code-of-ethics.pdf>
- Australian Psychological Society. (2022, June 20). Bleak new figures confirm depth of mental health crisis. <https://psychology.org.au/about-us/news-and-media/media-releases/2022/bleak-new-figures-confirm-depth-of-mental-health-c>
- Baker, E. K. (2003). *Caring for ourselves: A therapist's guide to personal and professional well-being*. American Psychological Association. <https://doi.org/10.1037/10482-000>

- Bakker, A. B., & Demerouti, E. (2017). Job demands–resources theory: Taking stock and looking forward. *Journal of Occupational Health Psychology, 22*(3), 273-285. <https://doi.org/10.1037/ocp0000056>
- Bakker, A. B., Demerouti, E., & Sanz-Vergel, A. (2023). Job demands–resources theory: Ten years later. *Annual review of organizational psychology and organizational behavior, 10*(1), 25-53. <https://doi.org/https://doi.org/10.1146/annurev-orgpsych-120920-053933>
- Bakker, A. B., Xanthopoulou, D., & Demerouti, E. (2023). How does chronic burnout affect dealing with weekly job demands? A test of central propositions in JD-R and COR-theories. *Applied Psychology, 72*(1), 389-410. <https://doi.org/https://doi.org/10.1111/apps.12382>
- Ballenger-Browning, K. K., Schmitz, K. J., Rothacker, J. A., Hammer, P. S., Webb-Murphy, J. A., & Johnson, D. C. (2011). Predictors of burnout among military mental health providers. *Military medicine, 176*(3), 253-260. <https://doi.org/https://doi.org/10.7205/MILMED-D-10-00269>
- Bamonti, P. M., Keelan, C. M., Larson, N., Mentrikoski, J. M., Randall, C. L., Sly, S. K., Travers, R. M., & McNeil, D. W. (2014). Promoting ethical behavior by cultivating a culture of self-care during graduate training: A call to action. *Training and Education in Professional Psychology, 8*(4), 253-260. <https://doi.org/10.1037/tep0000056>
- Barnard, L. K., & Curry, J. F. (2012). The relationship of clergy burnout to self-compassion and other personality dimensions. *Pastoral Psychology, 61*, 149-163. <https://doi.org/https://doi.org/10.1007/s11089-011-0377-0>
- Barnett, J. E., Baker, E. K., Elman, N. S., & Schoener, G. R. (2007). In pursuit of wellness: The self-care imperative. *Professional Psychology: Research and Practice, 38*(6), 603-612. <https://doi.org/https://doi.org/10.1037/0735-7028.38.6.603>
- Barnett, J. E., Johnston, L. C., & Hillard, D. (2005). Psychotherapist Wellness as an Ethical Imperative. In L. V. J. B. Allen (Ed.), *Innovations in clinical practice: Focus on health & wellness* (pp. 257–271). Professional Resource Press/Professional Resource Exchange.

- Bearse, J. L., McMinn, M. R., Seegobin, W., & Free, K. (2013). Barriers to psychologists seeking mental health care. *Professional Psychology: Research and Practice, 44*(3), 150-157.
<https://doi.org/10.1037/a0031182>
- Beaumont, E., Durkin, M., Hollins Martin, C. J., & Carson, J. (2016). Measuring relationships between self-compassion, compassion fatigue, burnout and well-being in student counsellors and student cognitive behavioural psychotherapists: A quantitative survey. *Counselling and Psychotherapy Research, 16*(1), 15-23. <https://doi.org/https://doi.org/10.1002/capr.12054>
- Beheshtifar, M., & Omidvar, A. R. (2013). Causes to create job burnout in organizations. *International Journal of Academic Research in Business and Social Sciences, 3*(6), 107-113.
- Biber, D. D., & Ellis, R. (2019). The effect of self-compassion on the self-regulation of health behaviors: A systematic review. *Journal of Health Psychology, 24*(14), 2060-2071.
<https://doi.org/10.1177/1359105317713361>
- Bluth, K., & Neff, K. D. (2018). New frontiers in understanding the benefits of self-compassion. *Self and Identity, 17*(6), 605-608. <https://doi.org/10.1080/15298868.2018.1508494>
- Bon, A. T., & Shire, A. M. (2022). Review of conservation of resources theory in job demands and resources model. *International Journal of Global Optimization and Its Application, 1*(4), 236-248.
[https://doi.org/ https://doi.org/10.56225/ijgoia.v1i4.102](https://doi.org/https://doi.org/10.56225/ijgoia.v1i4.102)
- Brion, J. M., Leary, M. R., & Drabkin, A. S. (2014). Self-compassion and reactions to serious illness: The case of HIV. *Journal of Health Psychology, 19*(2), 218-229.
<https://doi.org/10.1177/1359105312467391>
- Bucher, M. A., Samuel, D. B., & Suzuki, T. (2020). Survey and Interview Methods. In M. N. Hallquist & A. G. C. Wright (Eds.), *The Cambridge Handbook of Research Methods in Clinical Psychology* (pp. 45-53). Cambridge University Press. <https://doi.org/10.1017/9781316995808.007>

- Buonomo, I., Santoro, P. E., Benevene, P., Borrelli, I., Angelini, G., Fiorilli, C., Gualano, M. R., & Moscato, U. (2022). Buffering the effects of burnout on healthcare professionals' health—the mediating role of compassionate relationships at work in the COVID era. *International Journal of Environmental Research and Public Health*, *19*(15), 1-15.
<https://doi.org/10.3390/ijerph19158966>
- Butler, L. D., Mercer, K. A., McClain-Meeder, K., Horne, D. M., & Dudley, M. (2019). Six domains of self-care: Attending to the whole person. *Journal of Human Behavior in the Social Environment*, *29*(1), 107-124. <https://doi.org/10.1080/10911359.2018.1482483>
- Callan, S., Schwartz, J., & Arputhan, A. (2021). Training future psychologists to be competent in self-care: A systematic review. *Training and Education in Professional Psychology*, *15*(2), 117-125.
<https://doi.org/https://doi.org/10.1037/tep0000345>
- Cohen, J. (1992). Statistical Power Analysis. *Current Directions in Psychological Science*, *1*(3), 98-101.
<https://doi.org/10.1111/1467-8721.ep10768783>
- Coleman, C., Martensen, C., Scott, R., & Indelicato, N. A. (2016). Unpacking self-care: The connection between mindfulness, self-compassion, and self-care for counselors. *Counseling & Wellness: A Professional Counseling Journal*, *5*, 1-8.
- Collins, W. L. (2005). Embracing spirituality as an element of professional self-care. *Social Work & Christianity*, *32*(3), 263-274.
- Colman, D. E., Echon, R., Lemay, M. S., McDonald, J., Smith, K. R., Spencer, J., & Swift, J. K. (2016). The efficacy of self-care for graduate students in professional psychology: A meta-analysis. *Training and Education in Professional Psychology*, *10*(4), 188-197.
<https://doi.org/https://doi.org/10.1037/tep0000130>
- D'Souza, F., Egan, S. J., & Rees, C. S. (2011). The relationship between perfectionism, stress and burnout in clinical psychologists. *Behaviour Change*, *28*(1), 17-28. <https://doi.org/10.1375/bech.28.1.17>

- Dattilio, F. M. (2015). The Self-Care of Psychologists and Mental Health Professionals: A Review and Practitioner Guide. *Australian Psychologist*, *50*(6), 393-399. <https://doi.org/10.1111/ap.12157>
- Demerouti, E., Bakker, A. B., Nachreiner, F., & Schaufeli, W. B. (2001). The job demands-resources model of burnout. *Journal of applied Psychology*, *86*(3), 499-512. <https://doi.org/10.1037/0021-9010.86.3.499>
- Department of Health and Aged Care. (2022). *National Mental Health Workforce Strategy 2022-2032*. <https://www.health.gov.au/sites/default/files/2023-10/national-mental-health-workforce-strategy-2022-2032.pdf>
- Dev, V., Fernando, A. T., & Consedine, N. S. (2020). Self-compassion as a stress moderator: a cross-sectional study of 1700 doctors, nurses, and medical students. *Mindfulness*, *11*(5), 1170-1181. <https://doi.org/10.1007/s12671-020-01325-6>
- Dev, V., Fernando III, A. T., Lim, A. G., & Consedine, N. S. (2018). Does self-compassion mitigate the relationship between burnout and barriers to compassion? A cross-sectional quantitative study of 799 nurses. *International Journal of Nursing Studies*, *81*, 81-88. <https://doi.org/10.1016/j.ijnurstu.2018.02.003>
- Di Benedetto, M., & Swadling, M. (2014). Burnout in Australian psychologists: Correlations with work-setting, mindfulness and self-care behaviours. *Psychology, health & medicine*, *19*(6), 705-715. <https://doi.org/10.1080/13548506.2013.861602>
- Dorociak, K. E., Rupert, P. A., Bryant, F. B., & Zahniser, E. (2017). Development of a self-care assessment for psychologists. *Journal of Counseling Psychology*, *64*(3), 325-334. <https://doi.org/https://doi.org/10.1037/cou0000206>
- Dorociak, K. E., Rupert, P. A., & Zahniser, E. (2017). Work life, well-being, and self-care across the professional lifespan of psychologists. *Professional Psychology: Research and Practice*, *48*(6), 429-437. <https://doi.org/https://doi.org/10.1037/pro0000160>

- Dreison, K. C., Luther, L., Bonfils, K. A., Sliter, M. T., McGrew, J. H., & Salyers, M. P. (2018). Job burnout in mental health providers: A meta-analysis of 35 years of intervention research. *Journal of Occupational Health Psychology, 23*(1), 18-30. <https://doi.org/10.1037/ocp0000047>
- Duarte, C., Gilbert, P., Stalker, C., Catarino, F., Basran, J., Scott, S., Horgan, G., & Stubbs, R. J. (2021). Effect of adding a compassion-focused intervention on emotion, eating and weight outcomes in a commercial weight management programme. *Journal of Health Psychology, 26*(10), 1700-1715. <https://doi.org/10.1177/1359105319890019>
- Dunne, S., Sheffield, D., & Chilcot, J. (2018). Brief report: Self-compassion, physical health and the mediating role of health-promoting behaviours. *Journal of Health Psychology, 23*(7), 993-999. <https://doi.org/10.1177/1359105316643377>
- Durie, M. (1998). *Whaiora : Maori health development* (2nd ed.). Oxford University Press.
- El-Ghoroury, N. H., Galper, D. I., Sawaqdeh, A., & Bufka, L. F. (2012). Stress, coping, and barriers to wellness among psychology graduate students. *Training and Education in Professional Psychology, 6*(2), 122-134. <https://doi.org/https://doi.org/10.1037/a0028768>
- Eriksson, T., Germundsjö, L., Åström, E., & Rönnlund, M. (2018). Mindful self-compassion training reduces stress and burnout symptoms among practicing psychologists: A randomized controlled trial of a brief web-based intervention. *Frontiers in Psychology, 27*(9), 1-10. <https://doi.org/10.3389/fpsyg.2018.02340>
- Faul, F., Erdfelder, E., Buchner, A., & Lang, A.-G. (2009). Statistical power analyses using G*Power 3.1: Tests for correlation and regression analyses. *Behavior Research Methods, 41*(4), 1149-1160. <https://doi.org/10.3758/brm.41.4.1149>
- Ferrari, M., Dal Cin, M., & Steele, M. (2017). Self-compassion is associated with optimum self-care behaviour, medical outcomes and psychological well-being in a cross-sectional sample of adults with diabetes. *Diabetic Medicine, 34*(11), 1546-1553. <https://doi.org/10.1111/dme.13451>

- Ferrari, M., Hunt, C., Harrysunker, A., Abbott, M. J., Beath, A. P., & Einstein, D. A. (2019). Self-Compassion Interventions and Psychosocial Outcomes: a Meta-Analysis of RCTs. *Mindfulness*, 10(8), 1455-1473. <https://doi.org/10.1007/s12671-019-01134-6>
- Ferreira, C., Pinto-Gouveia, J., & Duarte, C. (2013). Self-compassion in the face of shame and body image dissatisfaction: Implications for eating disorders. *Eating behaviors*, 14(2), 207-210. <https://doi.org/10.1016/j.eatbeh.2013.01.005>
- Field, A. P. (2018). *Discovering Statistics Using IBM SPSS Statistics* (5th ed.). SAGE.
- Figley, C. R. (1995). Compassion fatigue: Toward a new understanding of the costs of caring. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators*. (pp. 3-28). The Sidran Press.
- Figley, C. R. (2002). Compassion fatigue: Psychotherapists' chronic lack of self care. *Journal of Clinical Psychology*, 58(11), 1433-1441. <https://doi.org/10.1002/jclp.10090>
- Finlay-Jones, A. L., Rees, C. S., & Kane, R. T. (2015). Self-Compassion, Emotion Regulation and Stress among Australian Psychologists: Testing an Emotion Regulation Model of Self-Compassion Using Structural Equation Modeling. *PLOS ONE*, 10(7), Article e0133481. <https://doi.org/10.1371/journal.pone.0133481>
- Freudenberger, H. J. (1974). Staff burn-out. *Journal of social issues*, 30(1), 159-165. <https://doi.org/https://doi.org/10.1111/j.1540-4560.1974.tb00706.x>
- Friis, A. M., Johnson, M. H., Cutfield, R. G., & Consedine, N. S. (2016). Kindness matters: a randomized controlled trial of a mindful self-compassion intervention improves depression, distress, and HbA1c among patients with diabetes. *Diabetes care*, 39(11), 1963-1971. <https://doi.org/10.2337/dc16-0416>

- Gardner, D., & O'Driscoll, M. P. (2007). Professional wellbeing. In J. J. R. M. O. D. I. M. Evans (Ed.), *Professional Practice of Psychology in Aotearoa New Zealand* (pp. 245-258). The New Zealand Psychological Society Inc.
- George-Levi, S., Schmidt-Barad, T., Natan, I., & Margalit, M. (2022). Sense of coherence and burnout among school psychologists: The moderating role of loneliness. *Current Psychology*, *41*(4), 2390-2397. <https://doi.org/10.1007/s12144-020-00766-5>
- Germer, C., & Neff, K. (2019). Mindful self-compassion (MSC). In I. Itzvan (Ed.), *The handbook of mindfulness-based programs: Every established intervention, from medicine to education* (pp. 357-367). Routledge.
- Germer, C. K., & Neff, K. D. (2013). Self-Compassion in Clinical Practice. *Journal of Clinical Psychology*, *69*(8), 856-867. <https://doi.org/10.1002/jclp.22021>
- Gilbert, P. (2014). The origins and nature of compassion focused therapy. *British Journal of Clinical Psychology*, *53*(1), 6-41. <https://doi.org/10.1111/bjc.12043>
- Gilroy, P. J., Carroll, L., & Murra, J. (2002). A preliminary survey of counseling psychologists' personal experiences with depression and treatment. *Professional Psychology: Research and Practice*, *33*(4), 402-407. <https://doi.org/https://doi.org/10.1037/0735-7028.33.4.402>
- Goetz, J. L., Keltner, D., & Simon-Thomas, E. (2010). Compassion: an evolutionary analysis and empirical review. *Psychological Bulletin*, *136*(3), 351-374. <https://doi.org/https://doi.org/10.1037/a0018807>
- Guertin, C., Barbeau, K., & Pelletier, L. (2020). Examining fat talk and self-compassion as distinct motivational processes in women's eating regulation: A self-determination theory perspective. *Journal of Health Psychology*, *25*(12), 1965-1977. <https://doi.org/10.1177/1359105318781943>
- Gunnell, K. E., Mosewich, A. D., McEwen, C. E., Eklund, R. C., & Crocker, P. R. (2017). Don't be so hard on yourself! Changes in self-compassion during the first year of university are associated with

changes in well-being. *Personality and Individual Differences*, 107, 43-48.

<https://doi.org/https://doi.org/10.1016/j.paid.2016.11.032>

Hashem, Z., & Zeinoun, P. (2020). Self-compassion explains less burnout among healthcare professionals. *Mindfulness*, 11(11), 2542-2551. <https://doi.org/10.1007/s12671-020-01469-5>

Hayes, A. F. (2022). *Introduction to Mediation, Moderation, and Conditional Process Analysis: A Regression-Based Approach* (3rd ed.). The Guilford Press.

He Ara Oranga. (2018). *Report of the Government Inquiry into Mental Health and Addiction*. Government Inquiry into Mental Health and Addiction.

Hobfoll, S. E. (1989). Conservation of resources: a new attempt at conceptualizing stress. *American Psychologist*, 44(3), 513-524. <https://doi.org/https://doi.org/10.1037/0003-066X.44.3.513>

Hobfoll, S. E., Halbesleben, J., Neveu, J.-P., & Westman, M. (2018). Conservation of resources in the organizational context: The reality of resources and their consequences. *Annual review of organizational psychology and organizational behavior*, 5(1), 103-128.

<https://doi.org/https://doi.org/10.1146/annurev-orgpsych-032117-104640>

Homan, K. J. (2016). Self-Compassion and Psychological Well-Being in Older Adults. *Journal of Adult Development*, 23(2), 111-119. <https://doi.org/10.1007/s10804-016-9227-8>

Homan, K. J., & Sirois, F. M. (2017). Self-compassion and physical health: Exploring the roles of perceived stress and health-promoting behaviors. *Health psychology open*, 4(2), Article 2055102917729542. <https://doi.org/https://doi.org/10.1177/2055102917729542>

Johnson, J., Hall, L. H., Berzins, K., Baker, J., Melling, K., & Thompson, C. (2018). Mental healthcare staff well-being and burnout: A narrative review of trends, causes, implications, and recommendations for future interventions. *International journal of mental health nursing*, 27(1), 20-32. <https://doi.org/10.1111/inm.12416>

- Kemper, K. J., Schwartz, A., Wilson, P. M., Mahan, J. D., Schubert, C. J., Staples, B. B., McClafferty, H., Serwint, J. R., & Batra, M. (2020). Burnout in pediatric residents: three years of national survey data. *Pediatrics*, *145*(1), Article e20191030. <https://doi.org/10.1542/peds.2019-1030>
- Kennedy, B. J., Tassell-Matamua, N. A., & Stiles-Smith, B. (2022). Psychology in Aotearoa New Zealand. In G. J. R. N. A. Ramkumar (Ed.), *Psychology in Oceania and the Caribbean* (pp. 115-132). Springer Nature Switzerland AG. https://doi.org/https://doi.org/10.1007/978-3-030-87763-7_8
- Kercher, A., & Gossage, L. (2024). Identifying risk factors for compassion fatigue in psychologists in Aotearoa, New Zealand, during the COVID-19 pandemic. *Professional Psychology: Research and Practice*, *55*(1), 28-38. <https://doi.org/https://doi.org/10.1037/pro0000538>
- Kotera, Y., Cockerill, V., Chircop, J., Kaluzeviciute, G., & Dyson, S. (2021). Predicting self-compassion in UK nursing students: Relationships with resilience, engagement, motivation, and mental wellbeing. *Nurse Education in Practice*, *51*, Article 102989. <https://doi.org/https://doi.org/10.1016/j.nepr.2021.102989>
- Kotera, Y., Tsuda-McCaie, F., Edwards, A.-M., Bhandari, D., & Maughan, G. (2021). Self-compassion in Irish social work students: relationships between resilience, engagement and motivation. *International Journal of Environmental Research and Public Health*, *18*(15), Article 8187. <https://doi.org/https://doi.org/10.3390/ijerph18158187>
- Krieger, T., Altenstein, D., Baettig, I., Doerig, N., & Holtforth, M. G. (2013). Self-Compassion in Depression: Associations With Depressive Symptoms, Rumination, and Avoidance in Depressed Outpatients. *Behavior Therapy*, *44*(3), 501-513. <https://doi.org/10.1016/j.beth.2013.04.004>
- Krieger, T., Berger, T., & Holtforth, M. g. (2016). The relationship of self-compassion and depression: Cross-lagged panel analyses in depressed patients after outpatient therapy. *Journal of Affective Disorders*, *202*, 39-45. <https://doi.org/10.1016/j.jad.2016.05.032>

- Kristensen, T. S., Borritz, M., Villadsen, E., & Christensen, K. B. (2005). The Copenhagen Burnout Inventory: A new tool for the assessment of burnout. *Work & stress, 19*(3), 192-207.
<https://doi.org/https://doi.org/10.1080/02678370500297720>
- Kumar, S. (2007). Burnout in psychiatrists. *World psychiatry, 6*(3), 186-189.
- Kumar, S., Hatcher, S., Dutu, G., Fischer, J., & Ma'u, E. (2011). Stresses experienced by psychiatrists and their role in burnout: a national follow-up study. *International Journal of Social Psychiatry, 57*(2), 166-179. <https://doi.org/10.1177/0020764009341211>
- Kumareswaran, S. (2023). Burnout among employees: a narrative review. *European Journal of Humanities and Social Sciences, 3*(2), 15-20. <https://doi.org/10.24018/ejsocial.2023.3.2.410>
- Leary, M. R., Tate, E. B., Adams, C. E., Allen, A. B., & Hancock, J. (2007). Self-compassion and reactions to unpleasant self-relevant events: the implications of treating oneself kindly. *Journal of Personality and Social Psychology, 92*(5), 887-904. <https://doi.org/10.1037/0022-3514.92.5.887>
- Lee, J. J., & Miller, S. E. (2013). A self-care framework for social workers: Building a strong foundation for practice. *Families in Society, 94*(2), 96-103. <https://doi.org/https://doi.org/10.1606/1044-3894.4289>
- Lee, J. J., Miller, S. E., & Bride, B. E. (2020). Development and initial validation of the self-care practices scale. *Social Work, 65*(1), 21-28. <https://doi.org/10.1093/sw/swz045>
- Lee, R. T., & Ashforth, B. E. (1996). A meta-analytic examination of the correlates of the three dimensions of job burnout. *Journal of applied Psychology, 81*(2), 123-133.
<https://doi.org/https://doi.org/10.1037/0021-9010.81.2.123>
- Leiter, M. P. (1993). Burnout as a developmental process: Consideration of models. In C. M. W. B. Schaufeli, & T. Marek (Ed.), *Professional burnout: Recent developments in theory and research*. (pp. 237-250). Taylor & Francis.

- Lianekhammy, J., Miller, J. J., Lee, J., Pope, N., Barnhart, S., & Grise-Owens, E. (2018). Exploring the self-compassion of health-care social workers: How do they fare? *Social work in health care*, 57(7), 563-580. <https://doi.org/https://doi.org/10.1080/00981389.2018.1471017>
- Little, R. J. (1988). A test of missing completely at random for multivariate data with missing values. *Journal of the American statistical Association*, 83(404), 1198-1202.
- Lizano, E. L. (2015). Examining the Impact of Job Burnout on the Health and Well-Being of Human Service Workers: A Systematic Review and Synthesis. *Human Service Organizations: Management, Leadership & Governance*, 39(3), 167-181. <https://doi.org/10.1080/23303131.2015.1014122>
- Macbeth, A., & Gumley, A. (2012). Exploring compassion: A meta-analysis of the association between self-compassion and psychopathology. *Clinical Psychology Review*, 32(6), 545-552. <https://doi.org/10.1016/j.cpr.2012.06.003>
- Mahoney, M. J. (1997). Psychotherapists' personal problems and self-care patterns. *Professional Psychology: Research and Practice*, 28(1), 14-16.
- Maslach, C. (1976). Burned-Out. *Human Behavior*, 9, 16-22.
- Maslach, C. (2003). Job burnout: New directions in research and intervention. *Current Directions in Psychological Science*, 12(5), 189-192. <https://doi.org/https://doi.org/10.1111/1467-8721.01258>
- Maslach, C., Jackson, S., & Leiter, M. (1997). The Maslach Burnout Inventory Manual. In R. J. W. C. P. Zalaquett (Ed.), *Evaluating Stress: A Book of Resources* (3 ed., pp. 191-218). The Scarecrow Press.
- Maslach, C., & Jackson, S. E. (1981). The measurement of experienced burnout. *Journal of Organizational Behavior*, 2(2), 99-113. <https://doi.org/https://doi.org/10.1002/job.4030020205>
- Maslach, C., & Leiter, M. P. (2007). Burnout. In G. Fink (Ed.), *Encyclopedia of Stress* (2 ed., pp. 368-371). Elsevier <https://doi.org/https://doi.org/10.1016/B978-012373947-6.00062-3>

- Maslach, C., & Pines, A. (1977). The burn-out syndrome in the day care setting. *Child care quarterly*, 6, 100-113. <https://doi.org/https://doi.org/10.1007/BF01554696>
- Maslach, C., Schaufeli, W. B., & Leiter, M. P. (2001). Job burnout. *Annual Review of Psychology*, 52(1), 397-422. <https://doi.org/https://doi.org/10.1146/annurev.psych.52.1.397>
- McCade, D., Frewen, A., & Fassnacht, D. B. (2021). Burnout and depression in Australian psychologists: The moderating role of self-compassion. *Australian Psychologist*, 56(2), 111-122. <https://doi.org/https://doi.org/10.1080/00050067.2021.1890979>
- McCormack, H. M., MacIntyre, T. E., O'Shea, D., Herring, M. P., & Campbell, M. J. (2018). The prevalence and cause (s) of burnout among applied psychologists: A systematic review. *Frontiers in Psychology*, 9, Article 1897. <https://doi.org/https://doi.org/10.3389/fpsyg.2018.01897>
- McCormick, K. (2014). *Restoring and strengthening resilience in the psychology profession: The RIO model of resilience for psychologists* [Doctor of Clinical Psychology Thesis, University of Auckland]. <https://researchspace.auckland.ac.nz/bitstream/handle/2292/23329/whole.pdf>
- Mental Health Australia. (2023). *2023-24 Federal Budget Summary*. https://mhaustralia.org/sites/default/files/docs/mental_health_australia_2023-24_federal_budget_summary.pdf
- Milfont, T. L., Denny, S., Ameratunga, S., Robinson, E., & Merry, S. (2008). Burnout and wellbeing: Testing the Copenhagen burnout inventory in New Zealand teachers. *Social Indicators Research*, 89, 169-177. <https://doi.org/https://doi.org/10.1007/s11205-007-9229-9>
- Miller, J. J., Grise-Owens, E., & Shalash, N. (2018). Investigating the self-care practices of social work faculty: An exploratory study. *Social Work Education*, 37(8), 1044-1059. <https://doi.org/https://doi.org/10.1080/02615479.2018.1470618>

- Miller, J. J., Lee, J., Niu, C., Grise-Owens, E., & Bode, M. (2019). Self-compassion as a predictor of self-care: A study of social work clinicians. *Clinical Social Work Journal*, 47(1), 321-331.
<https://doi.org/10.1007/s10615-019-00710-6>
- Miller, J. J., Lee, J., Shalash, N., & Poklembova, Z. (2020). Self-compassion among social workers. *Journal of Social Work*, 20(4), 448-462. <https://doi.org/10.1177/1468017319829404>
- Miller, J. J., Poklembova, Z., Podkowińska, M., Grise-Owens, E., Balogová, B., & Maria Pachner, T. (2021). Exploring the self-care practices of social workers in Poland. *European Journal of Social Work*, 24(1), 84-93. <https://doi.org/10.1080/13691457.2019.1653828>
- Mills, J., Wand, T., & Fraser, J. A. (2018). Examining self-care, self-compassion and compassion for others: a cross-sectional survey of palliative care nurses and doctors. *International Journal of Palliative Nursing*, 24(1), 4-11. <https://doi.org/10.12968/ijpn.2018.24.1.4>
- Ministry of Health. (2021). *Kia Manawanui Aotearoa: Long-term pathway to mental wellbeing*. .
https://www.health.govt.nz/system/files/2021-08/web3-kia-manawanui-aotearoa-v9_0.pdf
- Ministry of Health. (2022). *Annual Update of Key Results 2021/22: New Zealand Health Survey*.
<https://www.health.govt.nz/publications/annual-update-of-key-results-202122-new-zealand-health-survey>
- Morse, G., Salyers, M. P., Rollins, A. L., Monroe-DeVita, M., & Pfahler, C. (2012). Burnout in mental health services: A review of the problem and its remediation. *Administration and Policy in Mental Health and Mental Health Services Research*, 39, 341-352. <https://doi.org/https://doi.org/10.1007/s10488-011-0352-1>
- Neff, K. D. (2003a). The Development and Validation of a Scale to Measure Self-Compassion. *Self and Identity*, 2(3), 223-250. <https://doi.org/10.1080/15298860309027>
- Neff, K. D. (2003b). Self-Compassion: An Alternative Conceptualization of a Healthy Attitude Toward Oneself. *Self & Identity*, 2(2), 85-101. <https://doi.org/10.1080/15298860309032>

- Neff, K. D. (2016). The Self-Compassion Scale is a Valid and Theoretically Coherent Measure of Self-Compassion. *Mindfulness*, 7, 264–274. <https://doi.org/10.1007/s12671-015-0479-3>
- Neff, K. D. (2023a). Self-Compassion: Theory and Measurement. In A. Finlay-Jones, K. Bluth, & K. Neff (Eds.), *Handbook of Self-Compassion* (pp. 1-18). Springer International Publishing. https://doi.org/10.1007/978-3-031-22348-8_1
- Neff, K. D. (2023b). Self-Compassion: Theory, Method, Research, and Intervention. *Annual Review of Psychology*, 74(1), 193-218. <https://doi.org/10.1146/annurev-psych-032420-031047>
- Neff, K. D., & Dahm, K. (2015). Self-Compassion: What It Is, What It Does, and How It Relates to Mindfulness. In B. D. Ostafin, M. D. Robinson, & B. P. Meier (Eds.), *Handbook of Mindfulness and Self-Regulation* (pp. 121-137). Springer New York. https://doi.org/10.1007/978-1-4939-2263-5_10
- Neff, K. D., & Germer, C. K. (2013). A pilot study and randomized controlled trial of the mindful self-compassion program. *Journal of Clinical Psychology*, 69(1), 28-44. <https://doi.org/10.1002/jclp.21923>
- Neff, K. D., Kirkpatrick, K. L., & Rude, S. S. (2007). Self-compassion and adaptive psychological functioning. *Journal of research in personality*, 41(1), 139-154. <https://doi.org/https://doi.org/10.1016/j.jrp.2006.03.004>
- Neff, K. D., Knox, M. C., Long, P., & Gregory, K. (2020). Caring for others without losing yourself: An adaptation of the Mindful Self-Compassion Program for Healthcare Communities. *Journal of Clinical Psychology*, 76(9), 1543-1562. <https://doi.org/https://doi.org/10.1002/jclp.23007>
- Neff, K. D., & Pommier, E. (2013). The relationship between self-compassion and other-focused concern among college undergraduates, community adults, and practicing meditators. *Self and Identity*, 12(2), 160-176. <https://doi.org/https://doi.org/10.1080/15298868.2011.649546>

- Neff, K. D., & Tóth-Király, I. (2022). Self-compassion scale (SCS). In O. N. Medvedev, C. U. Krägeloh, R. J. Siegert, & N. N. Singh (Eds.), *Handbook of assessment in mindfulness research* (pp. 1-22). Springer. <https://doi.org/10.1007/978-3-030-77644-2>
- Neff, K. D., Tóth-Király, I., Knox, M. C., Kuchar, A., & Davidson, O. (2021). The Development and Validation of the State Self-Compassion Scale (Long- and Short Form). *Mindfulness*, *12*(1), 121-140. <https://doi.org/10.1007/s12671-020-01505-4>
- Neff, K. D., & Vonk, R. (2009). Self-compassion versus global self-esteem: two different ways of relating to oneself. *Journal of personality*, *77*(1), 23-50. <https://doi.org/10.1111/j.1467-6494.2008.00537.x>
- Nelson, J. R., Hall, B. S., Anderson, J. L., Birtles, C., & Hemming, L. (2018). Self-compassion as self-care: A simple and effective tool for counselor educators and counseling students. *Journal of Creativity in Mental Health*, *13*(1), 121-133. <https://doi.org/https://doi.org/10.1080/15401383.2017.1328292>
- Newell, J. M., & MacNeil, G. A. (2010). Professional burnout, vicarious trauma, secondary traumatic stress, and compassion fatigue: A review of theoretical terms, risk factors, and preventive methods for clinicians and researchers. *Best practices in mental health: An International Journal*, *6*(2), 57-68. <https://doi.org/10.70256/607490pbruec>
- Norcross, J. C., & VandenBos, G. R. (2018). *Leaving it at the office: A guide to psychotherapist self-care*. Guilford Publications.
- O'Connor, K., Muller Neff, D., & Pitman, S. (2018). Burnout in mental health professionals: A systematic review and meta-analysis of prevalence and determinants. *European Psychiatry*, *53*, 74-99. <https://doi.org/10.1016/j.eurpsy.2018.06.003>

- Pakenham, K. I. (2017). Training in acceptance and commitment therapy fosters self-care in clinical psychology trainees. *Clinical Psychologist*, 21(3), 186-194.
<https://doi.org/https://doi.org/10.1111/cp.12062>
- Pallant, J. (2020). *SPSS survival manual: a step by step guide to data analysis using IBM SPSS* (7th ed.). Routledge.
- Patsiopoulos, A. T., & Buchanan, M. J. (2011). The practice of self-compassion in counseling: A narrative inquiry. *Professional Psychology: Research and Practice*, 42(4), 301-307.
<https://doi.org/https://doi.org/10.1037/a0024482>
- Pavlova, A., & Consedine, N. S. (2023). Caring for the carer—Self-compassion in the health professions. In A. Finlay-Jones, K. Bluth, & K. Neff (Eds.), *Handbook of Self-Compassion* (pp. 231-250). Springer.
- Pines, A., & Aronson, E. (1988). *Career burnout: Causes and cures*. Free Press.
- Poole, M. (2023, June 30). Government mental health funding is being directed the wrong way. *The Canberra Times*. <https://www.canberratimes.com.au/story/8252208/government-ill-equipped-to-deal-with-mental-health-crisis/>
- Pope, K. S., & Tabachnick, B. G. (1994). Therapists as patients: A national survey of psychologists' experiences, problems, and beliefs. *Professional Psychology: Research and Practice*, 25(3), 247-258. <https://doi.org/https://doi.org/10.1037/0735-7028.25.3.247>
- Pope, K. S., Tabachnick, B. G., & Keith-Spiegel, P. (1987). Ethics of practice: The beliefs and behaviors of psychologists as therapists. *American Psychologist*, 42(11), 993-1006.
<https://doi.org/https://doi.org/10.1037/0003-066X.42.11.993>
- Posluns, K., & Gall, T. L. (2020). Dear mental health practitioners, take care of yourselves: A literature review on self-care. *International Journal for the Advancement of Counselling*, 42(1), 1-20.
<https://doi.org/10.1007/s10447-019-09382-w>

- Raes, F. (2010). Rumination and worry as mediators of the relationship between self-compassion and depression and anxiety. *Personality and Individual Differences, 48*(6), 757-761.
<https://doi.org/10.1016/j.paid.2010.01.023>
- Raes, F., Pommier, E., Neff, K. D., & Van Gucht, D. (2011). Construction and factorial validation of a short form of the Self-Compassion Scale. *Clinical Psychology & Psychotherapy, 18*(3), 250-255.
<https://doi.org/10.1002/cpp.702>
- Richard, A. A., & Shea, K. (2011). Delineation of self-care and associated concepts. *Journal of nursing scholarship, 43*(3), 255-264. <https://doi.org/10.1111/j.1547-5069.2011.01404.x>
- Richards, K. C., Campenni, C. E., & Muse-Burke, J. L. (2010). Self-care and well-being in mental health professionals: The mediating effects of self-awareness and mindfulness. *Journal of mental health counseling, 32*(3), 247-264.
<https://doi.org/https://doi.org/10.17744/mehc.32.3.0n31v88304423806>
- Rohland, B. M., Kruse, G. R., & Rohrer, J. E. (2004). Validation of a single-item measure of burnout against the Maslach Burnout Inventory among physicians. *Stress and Health: Journal of the International Society for the Investigation of Stress, 20*(2), 75-79.
<https://doi.org/https://doi.org/10.1002/smi.1002>
- Rohrer, J. M., Hünermund, P., Arslan, R. C., & Elson, M. (2022). That's a Lot to Process! Pitfalls of Popular Path Models. *Advances in Methods and Practices in Psychological Science, 5*(2), 1-14.
<https://doi.org/10.1177/25152459221095827>
- Rupert, P. A., & Dorociak, K. E. (2019). Self-care, stress, and well-being among practicing psychologists. *Professional Psychology: Research and Practice, 50*(5), 343-350.
<https://doi.org/https://doi.org/10.1037/pro0000251>

- Rupert, P. A., & Kent, J. S. (2007). Gender and work setting differences in career-sustaining behaviors and burnout among professional psychologists. *Professional Psychology: Research and Practice*, 38(1), 88-96. <https://doi.org/https://doi.org/10.1037/0735-7028.38.1.88>
- Rupert, P. A., Miller, A. O., & Dorociak, K. E. (2015). Preventing burnout: What does the research tell us? *Professional Psychology: Research and Practice*, 46(3), 168-174. <https://doi.org/https://doi.org/10.1037/a0039297>
- Rupert, P. A., & Morgan, D. J. (2005). Work setting and burnout among professional psychologists. *Professional Psychology: Research and Practice*, 36(5), 544-550. <https://doi.org/https://doi.org/10.1037/0735-7028.36.5.544>
- Rupert, P. A., Stevanovic, P., & Hunley, H. A. (2009). Work-family conflict and burnout among practicing psychologists. *Professional Psychology: Research and Practice*, 40(1), 54-61. <https://doi.org/https://doi.org/10.1037/a0012538>
- Salvagioni, D. A. J., Melanda, F. N., Mesas, A. E., González, A. D., Gabani, F. L., & Andrade, S. M. d. (2017). Physical, psychological and occupational consequences of job burnout: A systematic review of prospective studies. *PLOS ONE*, 12(10), Article e0185781. <https://doi.org/https://doi.org/10.1371/journal.pone.0185781>
- Sanchez-Reilly, S., Morrison, L. J., Carey, E., Bernacki, R., O'Neill, L., Kapo, J., Periyakoil, V. S., & Thomas, J. d. (2013). Caring for oneself to care for others: physicians and their self-care. *The journal of supportive oncology*, 11(2), 75-81. <https://doi.org/10.12788/j.suponc.0003>
- Schaufeli, W. B. (2003). Past performance and future perspectives of burnout research. *SA Journal of Industrial Psychology*, 29(4), 1-15. <https://doi.org/10.4102/sajip.v29i4.127>
- Schaufeli, W. B., Bakker, A. B., & Van Rhenen, W. (2009). How changes in job demands and resources predict burnout, work engagement, and sickness absenteeism. *Journal of Organizational*

- Behavior: The International Journal of Industrial, Occupational and Organizational Psychology and Behavior*, 30(7), 893-917. <https://doi.org/https://doi.org/10.1002/job.595>
- Schaufeli, W. B., Leiter, M. P., & Maslach, C. (2009). Burnout: 35 years of research and practice. *Career development international*, 14(3), 204-220.
<https://doi.org/https://doi.org/10.1108/13620430910966406>
- Schaufeli, W. B., & Taris, T. W. (2005). The conceptualization and measurement of burnout: Common ground and worlds apart. *Work & stress*, 19(3), 256-262.
<https://doi.org/https://doi.org/10.1080/02678370500385913>
- Seidler, A., Thinschmidt, M., Deckert, S., Then, F., Hegewald, J., Nieuwenhuijsen, K., & Riedel-Heller, S. G. (2014). The role of psychosocial working conditions on burnout and its core component emotional exhaustion—a systematic review. *Journal of occupational medicine and toxicology*, 9, 1-13. <https://doi.org/10.1186/1745-6673-9-10>
- Shapiro, S., & Fitch, A. (2023). Self-Compassion and Mindfulness. In A. Finlay-Jones, K. Bluth, & K. Neff (Eds.), *Handbook of Self-Compassion* (pp. 19-31). Springer. https://doi.org/10.1007/978-3-031-22348-8_2
- Shirom, A. (1989). Burnout in work organizations. In C. L. C. I. T. Robertson (Ed.), *International review of industrial and organizational psychology 1989*. (pp. 25-48). John Wiley & Sons.
- Shirom, A., & Melamed, S. (2005). Does burnout affect physical health? A review of the evidence. In A.-S. G. A. C. L. Cooper (Ed.), *Research companion to organizational health psychology* (pp. 599 - 622). Edward Elgar Publishing. <https://doi.org/https://doi.org/10.4337/9781845423308.00049>
- Siebert, D. C. (2005). Personal and occupational factors in burnout among practicing social workers: Implications for researchers, practitioners, and managers. *Journal of Social Service Research*, 32(2), 25-44. https://doi.org/https://doi.org/10.1300/J079v32n02_02

- Sim, W., Zanardelli, G., Loughran, M. J., Mannarino, M. B., & Hill, C. E. (2016). Thriving, burnout, and coping strategies of early and later career counseling center psychologists in the United States. *Counselling Psychology Quarterly*, 29(4), 382-404.
<https://doi.org/https://doi.org/10.1080/09515070.2015.1121135>
- Simionato, G. K., & Simpson, S. (2018). Personal risk factors associated with burnout among psychotherapists: A systematic review of the literature. *Journal of Clinical Psychology*, 74(9), 1431-1456. <https://doi.org/10.1002/jclp.22615>
- Simpson, S., Simionato, G., Smout, M., Van Vreeswijk, M. F., Hayes, C., Sougleris, C., & Reid, C. (2019). Burnout amongst clinical and counselling psychologist: The role of early maladaptive schemas and coping modes as vulnerability factors. *Clinical Psychology & Psychotherapy*, 26(1), 35-46.
<https://doi.org/https://doi.org/10.1002/cpp.2328>
- Sinclair, S., Raffin-Bouchal, S., Venturato, L., Mijovic-Kondejewski, J., & Smith-MacDonald, L. (2017). Compassion fatigue: A meta-narrative review of the healthcare literature. *International Journal of Nursing Studies*, 69, 9-24. <https://doi.org/10.1016/j.ijnurstu.2017.01.003>
- Sirois, F. M., & Hirsch, J. K. (2019). Self-compassion and adherence in five medical samples: The role of stress. *Mindfulness*, 10(1), 46-54. <https://doi.org/10.1007/s12671-018-0945-9>
- Sirois, F. M., Kitner, R., & Hirsch, J. K. (2015). Self-compassion, affect, and health-promoting behaviors. *Health Psychology*, 34(6), 661-669. <https://doi.org/https://doi.org/10.1037/hea0000158>
- Skovholt, T. M., Grier, T. L., & Hanson, M. R. (2001). Career counseling for longevity: Self-care and burnout prevention strategies for counselor resilience. *Journal of Career Development*, 27, 167-176. <https://doi.org/https://doi.org/10.1023/A:1007830908587>
- Smith, P. L., & Moss, S. B. (2009). Psychologist impairment: What is it, how can it be prevented, and what can be done to address it? *Clinical Psychology: Science and Practice*, 16(1), 1-15.
<https://doi.org/10.1111/j.1468-2850.2009.01137.x>

- Soit, H. (2023). *Analysing Australia's Mental Health Crisis* <https://psychology.org.au/about-us/news-and-media/aps-in-the-media/2023/analysing-australias-mental-health-crisis>
- Spence, A. (2022, July 28). 'Utterly overwhelmed': Child psychiatrists plead for urgent action to fix mental health staffing crisis. *The New Zealand Herald*. <https://www.nzherald.co.nz/nz/utterly-overwhelmed-child-psychiatrists-plead-for-urgent-action-to-fix-mental-health-staffing-crisis/VNUCWGRDDNRXNL6WBJ6L6N4K3A/>
- Spence, A. (2022, June 25). Great Minds: Children's mental health - Services at 'crisis point' as demand surges and staff depart. *The New Zealand Herald*. <https://www.nzherald.co.nz/nz/great-minds-childrens-mental-health-services-at-crisis-point-as-demand-surges-and-staff-depart/AKTYW7B4AAEL34QJ6L3H76VGZE/>
- Spence, A. (2022, May 19). Budget 2022: \$200m mental health boost is 'small bikkies' for a system in crisis. *The New Zealand Herald*. <https://www.nzherald.co.nz/nz/budget-2022-200m-mental-health-boost-is-small-bikkies-for-a-system-in-crisis/LA2FYU5WK2JZRL6T4IHECSTCA/>
- Stafford-Brown, J., & Pakenham, K. I. (2012). The Effectiveness of an ACT Informed Intervention for Managing Stress and Improving Therapist Qualities in Clinical Psychology Trainees. *Journal of Clinical Psychology*, 68(6), 592-513. <https://doi.org/10.1002/jclp.21844>
- Statistics New Zealand. (2005). *Statistical standard for ethnicity*. Statistics New Zealand.
- Stevanovic, P., & Rupert, P. A. (2004). Career-sustaining behaviors, satisfactions, and stresses of professional psychologists. *Psychotherapy: Theory, research, practice, training*, 41(3), 301-309.
- Tabachnick, B. G. (2019). *Using multivariate statistics* (7th ed.). Pearson.
- Tawfik, D. S., Scheid, A., Profit, J., Shanafelt, T., Trockel, M., Adair, K. C., Sexton, J. B., & Ioannidis, J. P. (2019). Evidence relating health care provider burnout and quality of care: a systematic review and meta-analysis. *Annals of internal medicine*, 171(8), 555-567. <https://doi.org/10.7326/M19-1152>

- Te Pou o te Whakaaro Nui. (2018). *Workforce stocktake: Final report to the Government Inquiry into Mental Health & Addiction, June 2018: New Zealand mental health and addiction workforce: challenges and solutions*. <https://mentalhealth.inquiry.govt.nz/assets/Summary-reports/Te-Pou-Stocktake.pdf>
- Terry, M. L., & Leary, M. R. (2011). Self-compassion, self-regulation, and health. *Self and Identity, 10*(3), 352-362. <https://doi.org/10.1080/15298868.2011.558404>
- The New Zealand Psychological Society. (2002). *Code of Ethics For Psychologists Working in Aotearoa/New Zealand*. <https://www.nzccp.co.nz/assets/Uploads/Code-of-Ethics-English.pdf>
- Tiwari, G. K., Pandey, R., Rai, P. K., Pandey, R., Verma, Y., Parihar, P., Ahirwar, G., Tiwari, A. S., & Mandal, S. P. (2020). Self-compassion as an intrapersonal resource of perceived positive mental health outcomes: A thematic analysis. *Mental Health, Religion & Culture, 23*(7), 550-569. <https://doi.org/https://doi.org/10.1080/13674676.2020.1774524>
- Van Mol, M. M., Kompanje, E. J., Benoit, D. D., Bakker, J., & Nijkamp, M. D. (2015). The prevalence of compassion fatigue and burnout among healthcare professionals in intensive care units: a systematic review. *PLOS ONE, 10*(8), Article e0136955. <https://doi.org/10.1371/journal.pone.0136955>
- Warlick, C. A., Van Gorp, A., Farmer, N. M., Patterson, T., & Armstrong, A. (2021). Comparing burnout between graduate-level and professional clinicians. *Training and Education in Professional Psychology, 15*(2), 150-158. <https://doi.org/https://doi.org/10.1037/tep0000328>
- Williams, A. M., Reed, B., Self, M. M., Robiner, W. N., & Ward, W. L. (2020). Psychologists' practices, stressors, and wellness in academic health centers. *Journal of clinical psychology in medical settings, 27*, 818-829. <https://doi.org/10.1007/s10880-019-09678-4>

- Williams, M. N., Gomez Grajales, C. A., & Kurkiewicz, D. (2013). Assumptions of Multiple Regression: Correcting Two Misconceptions. *Practical Assessment, Research & Evaluation, 18*(11), 1-14.
<https://doi.org/10.7275/55hn-wk47>
- Wise, E. H., & Barnett, J. E. (2016). Self-care for psychologists. In G. R. V. J. C. Norcross, D. K. Freedheim, & L. F. Campbell (Ed.), *APA handbook of clinical psychology: Education and profession* (pp. 209–222). American Psychological Association. <https://doi.org/https://doi.org/10.1037/14774-014>
- Wise, E. H., Hersh, M. A., & Gibson, C. M. (2012). Ethics, self-care and well-being for psychologists: Reenvisioning the stress-distress continuum. *Professional Psychology: Research and Practice, 43*(5), 487-494. <https://doi.org/https://doi.org/10.1037/a0029446>
- Wise, E. H., & Reuman, L. (2019). Promoting competent and flourishing life-long practice for psychologists: A communitarian perspective. *Professional Psychology: Research and Practice, 50*(2), 129-135. <https://doi.org/https://doi.org/10.1037/pro0000226>
- Yang, Y., & Hayes, J. A. (2020). Causes and consequences of burnout among mental health professionals: A practice-oriented review of recent empirical literature. *Psychotherapy, 57*(3), 426-436.
<https://doi.org/10.1037/pst0000317>
- Zahniser, E., Rupert, P. A., & Dorociak, K. E. (2017). Self-care in clinical psychology graduate training. *Training and Education in Professional Psychology, 11*(4), 283-289.
<https://doi.org/https://doi.org/10.1037/tep0000172>
- Zessin, U., Dickhäuser, O., & Garbade, S. (2015). The Relationship Between Self-Compassion and Well-Being: A Meta-Analysis. *Applied Psychology: Health and Well-Being, 7*(3), 340-364.
<https://doi.org/10.1111/aphw.12051>

Appendix A – New Zealand Information Sheet and Questionnaire



Information page



How can we improve self-care practices and reduce burnout within New Zealand psychologists? Examining self-compassion and its link to self-care and burnout.

Information Sheet

Who am I and why am I conducting this research?

My name is Siobhan Matheson, I am originally from Auckland, New Zealand and I am currently living in Brisbane, Australia. I am conducting research as part of the requirements towards a Master of Arts majoring in Psychology at Massey University. My research is supervised by Dr Kirsty Ross, Senior lecturer in the School of Psychology at Massey University, and Registered Clinical Psychologist.

The demanding nature of psychologists' work and their exposure to sensitive and distressing content puts them at risk of experiencing heightened stress and burnout. Burnout has been linked to a variety of negative outcomes both for the individual psychologist and their clients. Self-care is widely known as important for improving wellbeing and preventing negative stress outcomes such as burnout; however, few studies have systematically investigated the link between the two within psychologists. Further, despite the importance of self-care, psychologists have been found to have a chronic disregard for their own needs, often putting the needs of their clients above their own. Given the risks associated with burnout and insufficient engagement in self-care, there is a need to investigate factors that may contribute to psychologists' engagement in self-care, particularly within a NZ context.

What is the research about?

The purpose of this research is to investigate whether self-compassion is a factor by which psychologists' engagement in self-care practices can be increased. This research will also explore the relationship between self-care, self-compassion and burnout in New Zealand psychologists, investigating whether self-compassion may strengthen (moderate) the association between self-care and burnout.

Who can participate and why get involved?

All psychologists registered with the New Zealand Psychologists Board and holding a current practising certificate are invited to participate in this research. Participation in this research is voluntary and entirely anonymous, however, your participation will be greatly appreciated. Your contribution will help us to explore the role that self-compassion may have in improving psychologists' engagement in self-care practices and reducing the risk of burnout within the profession.

What will participation in the survey involve?

Participation involves completion of an anonymous, online survey that will take approximately 15 minutes to complete. The survey includes questions on demographic characteristics as well as standardised measures of self-compassion, self-care practices and burnout. All questions in the survey are close-ended and instructions on how to respond to questions in each section are included.

Completion and submission of the survey implies consent and you have the right to decline to answer any particular question(s) should you choose. It is not expected that participation in this survey will cause any distress. Should you experience any concerns following completion of the survey, you are encouraged to contact your supervisor. Alternatively, please contact Lifeline on 0800 543 35 or Need to talk? via phone call or text on 1737.

Collected data will be used for research purposes only and will be stored on a secure hard-drive for a period of five-years before being destroyed. Upon completing the survey, you will be given the opportunity to enter a confidential, independent **prize draw to win one of 10 \$50 gift cards**. At this stage, you will also be given the opportunity to receive a summary of the research findings. Privacy will be protected when opting into the prize draw as you will be taken to a secure link, separate from the original survey to enter contact details. There is no link between the two data sets other than the time and date. It has been confirmed from previous survey research that names could not be linked to participant responses on the primary survey.

Thank you in advance for your time and consideration.

Kind regards,
Siobhan Matheson

Contact information

If you have any questions or queries regarding this project, please don't hesitate to contact the following:

Researcher

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This project has been reviewed and approved by the Massey University Human Ethics Committee:

Southern A, Application 22/04.

If you have any concerns about the conduct of this research, please contact Dr Negar Partow, Chair,

Massey University Human Ethics Committee: Southern A,

telephone 04 801 5799 x 63363, email humanethicsoutha@massey.ac.nz.

Consent

Respondent Consent

Thank you for participating in this questionnaire.

Your participation implies consent.

You have the right to decline to answer any particular question.

I have read and understood the information sheet for this study and consent to collection of my responses.

(Please click on the 'Yes' choice if you wish to proceed.)

- Yes
- No

Screening

Are you currently registered with the NZ Psychologists Board?

- Yes, I am registered with the NZPB
- No, I am not registered with the NZPB

Do you hold a current practising certificate?

- Yes
- No

Demographics and Work/Personal Characteristics

Demographics and Work/Personal Characteristics

What is your scope of practice?

- Psychologist
- Intern/Trainee Psychologist
- Counselling Psychologist
- Clinical Psychologist
- Neuropsychologist
- Educational Psychologist

How many years have you worked in psychological practice?

- 0 - 5
- 6 - 10
- 11 - 15
- 16 - 20
- 20+

In what kind of setting do you work?

Select as many as apply.

- Government/health funded organisation (e.g. DHBs, Oranga Tamariki, Hospitals, Prisons and correctional facilities, Department of Corrections)
- Non-government organisation (e.g. charity psychological organisations)
- Private sector (e.g., Private clinics)
- School
- University
- Other (please specify)

How many hours, on average, do you work per week in psychological practice?

- 0 - 5
- 6 - 10
- 11 - 15
- 16 - 20
- 21 - 25
- 26 - 30
- 31 - 35
- 36 - 40
- 40+

How old are you?

This can be made a drop down set of options as all ages as needed

- | | |
|-----------------------------------|---|
| <input type="radio"/> 20-25 years | <input type="radio"/> 46-50 years |
| <input type="radio"/> 26-30 years | <input type="radio"/> 51-55 years |
| <input type="radio"/> 31-35 years | <input type="radio"/> 56-60 years |
| <input type="radio"/> 36-40 years | <input type="radio"/> Greater than 60 years |
| <input type="radio"/> 41-45 years | |

Which gender do you identify with?

- Male
- Female
- Non-binary
- Prefer not to say
- Other (please specify)

Which ethnic group(s) do you identify with?

- Māori
- Pākehā/New Zealand European
- Pacifika
- Asian
- Middle Eastern
- Latin American
- African
- Other ethnicity (Please specify)

Self-Compassion Scale - Short Form (SCS)

How I typically act towards myself in difficult times.

Please read each statement carefully before answering. For each item, please indicate how often you behave in the stated manner, using the following scale:

[Almost Never] 1 2 3 4 5 *[Almost Always]*

	Almost Never				Almost Always
	1	2	3	4	5
When I fail at something important to me I become consumed by feelings of inadequacy.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I try to be understanding and patient towards those aspects of my personality I don't like.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
When something painful happens I try to take a balanced view of the situation.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
When I'm feeling down, I tend to feel like most other people are probably happier than I am.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	1	2	3	4	5
I try to see my failings as part of the human condition.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
When I'm going through a very hard time, I give myself the caring and tenderness I need.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
When something upsets me I try to keep my emotions in balance.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
When I fail at something that's important to me, I tend to feel alone in my failure.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	1	2	3	4	5

When I'm feeling down I tend to obsess and fixate on everything that's wrong.

When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people.

I'm disapproving and judgmental about my own flaws and inadequacies.

I'm intolerant and impatient towards those aspects of my personality I don't like.

Self-Care Practices Scale (SCPS)

Self-Care Practices Scale (SCPS)

Assessing the frequency of engagement in both personal and professional self-care practices.

Professional self-care

Please read each statement carefully before answering and keep in mind that there are no right or wrong answers. For each item, please indicate how frequently you engage in each of the following by choosing the number for each item below that best fits you, using the following scale:

[Never] 1 2 3 4 5 [Very Often]

	Never				Very Often
	0	1	2	3	4
I take small breaks throughout the workday.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I seek out professional development opportunities.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I take vacations.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I acknowledge my success at work.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I problem solve when I have challenges at work.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	0	1	2	3	4
I reserve work tasks for designated work hours (e.g. paperwork, emails, work-related colleague contact).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I attend to feelings of being overwhelmed with my work.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I seek out colleagues I find supportive.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am able to say "no" when appropriate.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Personal self-care

Please read each statement carefully before answering and keep in mind that there are no right or wrong answers. For each item, please indicate how frequently you engage in each of the following by choosing the number for each item below that best fits you, using the following scale:

[Never] 1 2 3 4 5 *[Very Often]*

	Never				Very Often
	0	1	2	3	4
I engage in physical activities.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I laugh.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I engage in spiritual practices.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I get adequate sleep for my body.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I spend quality time with people I care about.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	0	1	2	3	4
I participate in activities that I enjoy.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I accept help from others.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I engage in physical intimacy.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I take action to meet my emotional needs.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Copenhagen Burnout Inventory (CBI)

Copenhagen Burnout Inventory (CBI)

The scale is used to measure burnout in relation to personal, work-related or client-related burnout.

Personal Burnout

Please read each statement carefully before answering. For each item, please indicate how often you identify with the below statements, using the following scales:

	Never/ Almost Never	Seldom	Sometimes	Often	Always
How often do you feel tired?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How often are you physically exhausted?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How often are you emotionally exhausted?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Never/ Almost Never	Seldom	Sometimes	Often	Always
How often do you think: "I can't take it anymore"?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How often do you feel worn out?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How often do you feel weak and susceptible to illness?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Work-related Burnout

Please read each statement carefully before answering. For each item, please indicate how often you identify with the below statements, using the following scales:

	To a very low degree	To a low degree	Somewhat	To a high degree	To a very high degree
Is your work emotionally exhausting?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Do you feel burnt out because of your work?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Does your work frustrate you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please read each statement carefully before answering. For each item, please indicate how often you identify with the below statements, using the following scales:

	Never/ Almost Never	Seldom	Sometimes	Often	Always
Do you feel worn out at the end of the working day?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Are you exhausted in the morning at the thought of another day at work?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Do you feel that every working hour is tiring for you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Do you have enough energy for Whānau and friends during leisure time?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Client-related Burnout

Please read each statement carefully before answering. For each item, please indicate how often you identify with the below statements, using the following scales:

	To a very low degree	To a low degree	Somewhat	To a high degree	To a very high degree
Do you find it hard to work with clients?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Do you find it frustrating to work with clients?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Does it drain your energy to work with clients?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Do you feel that you give more than you get back when you work with clients?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please read each statement carefully before answering. For each item, please indicate how often you identify with the below statements, using the following scales:

	Never/ Almost Never	Seldom	Sometimes	Often	Always
Are you tired of working with clients?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Do you sometimes wonder how long you will be able to continue working with clients?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Support

Support lines

If any parts of the survey have caused you distress, you are encouraged to speak with your supervisor or contact the following free support line options:

- **Lifeline:** 0800 543 35
- **Need to talk?:** 1737 call or text

End

Prize Draw & Results Summary

Clicking the **Submit** button below will submit your responses and then transfer you to a separate, optional survey to collect contact details if you wish to participate in a prize draw to win one of ten gift vouchers or request a summary of results.

Powered by Qualtrics

Appendix B – Australian Information sheet and questionnaire



Information page



How can we improve self-care practices and reduce burnout within New Zealand and Australian psychologists? Examining self-compassion and its link to self-care and burnout.

Information Sheet

Who am I and why am I conducting this research?

My name is Siobhan Matheson, I am originally from Auckland, New Zealand and I am currently living in Brisbane, Australia. I am conducting research as part of the requirements towards a Master of Arts majoring in Psychology at Massey University. My research is supervised by Dr Kirsty Ross, Senior lecturer in the School of Psychology at Massey University, and Registered Clinical Psychologist.

The demanding nature of psychologists' work and their exposure to sensitive and distressing content puts them at risk of experiencing heightened stress and burnout. Burnout has been linked to a variety of negative outcomes both for the individual psychologist and their clients. Self-care is widely known as important for improving wellbeing and preventing negative stress outcomes such as burnout; however, few studies have systematically investigated the link between the two within psychologists. Further, despite the importance of self-care, psychologists have been found to have a chronic disregard for their own needs, often putting the needs of their clients above their own. Given the risks associated with burnout and insufficient engagement in self-care, there is a need to investigate factors that may contribute to psychologists' engagement in self-care, particularly within a New Zealand and Australian context.

What is the research about?

The purpose of this research is to investigate whether self-compassion is a factor by which psychologists' engagement in self-care practices can be increased. This research will also explore the relationship between self-care, self-compassion and burnout in New Zealand and Australian psychologists, investigating whether self-compassion may strengthen (moderate) the association between self-care and burnout.

Who can participate and why get involved?

All psychologists registered with the New Zealand or Australian Psychologists Board and holding a current practising certificate are invited to participate in this research.

Participation in this research is voluntary and entirely anonymous, however, your participation will be greatly appreciated. Your contribution will help us to explore the role that self-compassion may have in improving psychologists' engagement in self-care practices and reducing the risk of burnout within the profession.

What will participation in the survey involve?

Participation involves completion of an anonymous, online survey that will take approximately 15 minutes to complete. The survey includes questions on demographic characteristics as well as standardised measures of self-compassion, self-care practices and burnout. All questions in the survey are close-ended and instructions on how to respond to questions in each section are included.

Completion and submission of the survey implies consent and you have the right to decline to answer any particular question(s) should you choose. It is not expected that participation in this survey will cause any distress. Should you experience any concerns following completion of the survey, you are encouraged to contact your supervisor. Alternatively, please contact Lifeline NZ on 0800 543 35 or Lifeline Australia on 13 11 14.

Collected data will be used for research purposes only and will be stored on a secure hard-drive for a period of five-years before being destroyed. Upon completing the survey, you will be given the opportunity to enter a confidential, independent **prize draw to win one of 10 \$50 gift cards**. At this stage, you will also be given the opportunity to receive a summary of the research findings. Privacy will be protected when opting into the prize draw as you will be taken to a secure link, separate from the original survey to enter contact details. There is no link between the two data sets other than the time and date. It has been confirmed from previous survey research that names could not be linked to participant responses on the primary survey.

Thank you in advance for your time and consideration.

Kind regards,
Siobhan Matheson

Contact information

If you have any questions or queries regarding this project, please don't hesitate to

contact the following:

Researcher

Siobhan Matheson
 School of Psychology
 Massey University
 Palmerston North
 New Zealand
 Email: siobhan.matheson.1@uni.massey.ac.nz

Supervisor

Dr Kirsty Ross
 School of Psychology
 Massey University
 New Zealand
 +64 6 951-7968
k.j.ross@massey.ac.nz

**Te Kunenga
 ki Pūrehuroa**

Massey University School of Psychology – Te Kura Hinengaro Tangata
 Wellington, New Zealand
 T +64 4 801-5799 ext 85071 : W psychology.massey.ac.nz

This project has been reviewed and approved by the Massey University Human Ethics Committee:

Southern A, Application 22/04.

If you have any concerns about the conduct of this research, please contact Dr Negar Partow, Chair,

Massey University Human Ethics Committee: Southern A,

telephone 04 801 5799 x 63363, email humanethicsoutha@massey.ac.nz.

Consent

Respondent Consent

Thank you for participating in this questionnaire.

Your participation implies consent.

You have the right to decline to answer any particular question.

I have read and understood the information sheet for this study and consent to collection of my responses.

(Please click on the 'Yes' choice if you wish to proceed.)

- Yes
- No

Screening

Are you currently registered with the NZ or Australian Psychologists Board?

- Yes, I am registered with the NZ or Australian Psychologists Board
- No, I am not registered with the NZ or Australian Psychologists Board

Do you hold a current practising certificate?

- Yes
- No

Demographics and Work/Personal Characteristics

Demographics and Work/Personal Characteristics

What is your scope of practice?

- Psychologist
- Intern/Trainee Psychologist
- Counselling Psychologist
- Clinical Psychologist
- Neuropsychologist
- Educational Psychologist
- Other

How many years have you worked in psychological practice?

- 0 - 5
- 6 - 10
- 11 - 15
- 16 - 20
- 20+

In what kind of setting do you work?

Select as many as apply.

- Government/health funded organisation (e.g. DHBs, Oranga Tamariki, Hospitals, Prisons and correctional facilities, Department of Corrections)
- Non-government organisation (e.g. charity psychological organisations)
- Private sector (e.g., Private clinics)
- School
- University
- Other (please specify)

How many hours, on average, do you work per week in psychological practice?

- 0 - 5
- 6 - 10
- 11 - 15
- 16 - 20
- 21 - 25
- 26 - 30
- 31 - 35
- 36 - 40
- 40+

How old are you?

- 20-25 years
- 26-30 years
- 31-35 years
- 36-40 years
- 41-45 years
- 46-50 years
- 51-55 years
- 56-60 years
- Greater than 60 years

Which gender do you identify with?

- Male
- Female
- Non-binary
- Prefer not to say
- Other (please specify)

Which ethnic group(s) do you identify with?

- Māori
- Pākehā/New Zealand European
- Australian European
- Aboriginal/Torres Strait Islander
- Pacifika
- Asian
- Middle Eastern
- Latin American
- African
- Other ethnicity (Please specify)

Self-Compassion Scale - Short Form (SCS)

How I typically act towards myself in difficult times.

Please read each statement carefully before answering. For each item, please indicate how often you behave in the stated manner, using the following scale:

[Almost Never] 1 2 3 4 5 *[Almost Always]*

	Almost Never					Almost Always	
	1	2	3	4	5		
When I fail at something important to me I become consumed by feelings of inadequacy.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
I try to be understanding and patient towards those aspects of my personality I don't like.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
When something painful happens I try to take a balanced view of the situation.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
When I'm feeling down, I tend to feel like most other people are probably happier than I am.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
	1	2	3	4	5		
I try to see my failings as part of the human condition.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
When I'm going through a very hard time, I give myself the caring and tenderness I need.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
When something upsets me I try to keep my emotions in balance.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
When I fail at something that's important to me, I tend to feel alone in my failure.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
	1	2	3	4	5		

When I'm feeling down
I tend to obsess and
fixate on everything
that's wrong.

When I feel inadequate
in some way, I try to
remind myself that
feelings of inadequacy
are shared by most
people.

I'm disapproving and
judgmental about my
own flaws and
inadequacies.

I'm intolerant and
impatient towards
those aspects of my
personality I don't like.

Self-Care Practices Scale (SCPS)

Self-Care Practices Scale (SCPS)

Assessing the frequency of engagement in both personal and professional self-care practices.

Professional self-care

Please read each statement carefully before answering and keep in mind that there are no right or wrong answers. For each item, please indicate how frequently you engage in each of the following by choosing the number for each item below that best fits you, using the following scale:

[Never] 1 2 3 4 5 *[Very Often]*

	Never				Very Often
	0	1	2	3	4
I take small breaks throughout the workday.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I seek out professional development opportunities.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I take vacations.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I acknowledge my success at work.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I problem solve when I have challenges at work.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	0	1	2	3	4
I reserve work tasks for designated work hours (e.g. paperwork, emails, work-related colleague contact).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I attend to feelings of being overwhelmed with my work.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I seek out colleagues I find supportive.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am able to say "no" when appropriate.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Personal self-care

Please read each statement carefully before answering and keep in mind that there are no right or wrong answers. For each item, please indicate how frequently you engage in each of the following by choosing the number for each item below that best fits you, using the following scale:

[Never] 1 2 3 4 5 *[Very Often]*

	Never				Very Often
	0	1	2	3	4
I engage in physical activities.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I laugh.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I engage in spiritual practices.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I get adequate sleep for my body.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I spend quality time with people I care about.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	0	1	2	3	4
I participate in activities that I enjoy.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I accept help from others.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I engage in physical intimacy.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I take action to meet my emotional needs.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Copenhagen Burnout Inventory (CBI)

Copenhagen Burnout Inventory (CBI)

The scale is used to measure burnout in relation to personal, work-related or client-related burnout.

Personal Burnout

Please read each statement carefully before answering. For each item, please indicate how often you identify with the below statements, using the following scales:

	Never/ Almost Never	Seldom	Sometimes	Often	Always
How often do you feel tired?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How often are you physically exhausted?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How often are you emotionally exhausted?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	Never/ Almost Never	Seldom	Sometimes	Often	Always
How often do you think: "I can't take it anymore"?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How often do you feel worn out?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How often do you feel weak and susceptible to illness?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Work-related Burnout

Please read each statement carefully before answering. For each item, please indicate how often you identify with the below statements, using the following scales:

	To a very low degree	To a low degree	Somewhat	To a high degree	To a very high degree
Is your work emotionally exhausting?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Do you feel burnt out because of your work?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Does your work frustrate you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please read each statement carefully before answering. For each item, please indicate how often you identify with the below statements, using the following scales:

	Never/ Almost Never	Seldom	Sometimes	Often	Always
Do you feel worn out at the end of the working day?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Are you exhausted in the morning at the thought of another day at work?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Do you feel that every working hour is tiring for you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Do you have enough energy for Whānau and friends during leisure time?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Client-related Burnout

Please read each statement carefully before answering. For each item, please indicate how often you identify with the below statements, using the following scales:

	To a very low degree	To a low degree	Somewhat	To a high degree	To a very high degree
Do you find it hard to work with clients?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Do you find it frustrating to work with clients?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Does it drain your energy to work with clients?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Do you feel that you give more than you get back when you work with clients?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please read each statement carefully before answering. For each item, please indicate how often you identify with the below statements, using the following scales:

	Never/ Almost Never	Seldom	Sometimes	Often	Always
Are you tired of working with clients?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Do you sometimes wonder how long you will be able to continue working with clients?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Support

Support lines

If any parts of the survey have caused you distress, you are encouraged to speak with your supervisor or contact the following free support line options:

- **Lifeline NZ:** 0800 543 35
- **Lifeline Australia:** 13 11 14
- **Need to talk?:** 1737 call or text

End

Prize Draw & Results Summary

Clicking the **Submit** button below will submit your responses and then transfer you to a separate, optional survey to collect contact details if you wish to participate in a prize draw to win one of ten gift vouchers or request a summary of results.

Powered by Qualtrics

Appendix C - Request for Assistance Email NZPS



MASSEY UNIVERSITY
COLLEGE OF HUMANITIES
AND SOCIAL SCIENCES
TE KURA PŪKENGĀ TANGATA

New Zealand Psychological Society
PO Box 10536
The Terrace
Wellington, 6143
New Zealand

RE: Master of Arts (Psychology) Research Project

Kia ora,

My name is Siobhan Matheson and I am currently completing a Master of Arts (Psychology) Degree at Massey University. The research I am conducting as part of my Master's is titled: How can we improve self-care practices and reduce burnout within New Zealand and Australian psychologists? Examining self-compassion and its link to self-care and burnout. This research will be conducted under the supervision of Dr Kirsty Ross, Senior Lecturer in the School of Psychology at Massey University, and Registered Clinical Psychologist. I am contacting you as I would appreciate your help in recruiting participants for my research.

I am looking for current registered and practicing New Zealand and Australian psychologists to complete an online, anonymous survey. The survey will take approximately 15 minutes to complete and includes questions on demographic factors, as well as measures on self-compassion, self-care practices, and burnout. I would be grateful if you could please consider contacting your members and advising them of the opportunity to take part in this research using the attached advertising email. I have also attached a detailed information sheet for your review and consideration.

Please let me know if you are interested and willing to help with participant recruitment. I am happy to answer any questions you may have and supply you with any additional information that you may require.

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern A, Application 22/04. If you have any concerns about the conduct of this research, please contact Dr Negar Partow, Chair, Massey University Human Ethics Committee: Southern A, telephone 04 801 5799 x 63363, email humanethicsoutha@massey.ac.nz.

Research contacts:

Researcher: Siobhan Matheson

E-mail: [REDACTED]

Phone: [REDACTED]

Supervisor: Dr Kirsty Ross

E-mail: K.J.Ross@massey.ac.nz

Phone: +64 6 951 7968

Thank you in advance for taking the time to consider my request, I look forward to hearing back from you.

Kind regards,

Siobhan Matheson

Appendix D - Request for Assistance Email NZCCP



MASSEY UNIVERSITY
COLLEGE OF HUMANITIES
AND SOCIAL SCIENCES
TE KURA PŪKENGĀ TANGATA

New Zealand College of Clinical Psychologists
Level 6, NZLC
186 Willis Street
Wellington, 6143
New Zealand

RE: Master of Arts (Psychology) Research Project

Kia ora,

My name is Siobhan Matheson and I am currently completing a Master of Arts (Psychology) Degree at Massey University. The research I am conducting as part of my Master's is titled: [How can we improve self-care practices and reduce burnout within New Zealand and Australian psychologists? Examining self-compassion and its link to self-care and burnout.](#) This research will be conducted under the supervision of Dr Kirsty Ross, Senior Lecturer in the School of Psychology at Massey University, and Registered Clinical Psychologist. I am contacting you as I would appreciate your help in recruiting participants for my research.

I am looking for current registered and practicing New Zealand and Australian psychologists to complete an online, anonymous survey. The survey will take approximately 15 minutes to complete and includes questions on demographic factors, as well as measures on self-compassion, self-care practices, and burnout. I would be grateful if you could please consider contacting your members and advising them of the opportunity to take part in this research using the attached advertising email. I have also attached a detailed information sheet for your review and consideration.

Please let me know if you are interested and willing to help with participant recruitment. I am happy to answer any questions you may have and supply you with any additional information that you may require.

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern A, Application 22/04. If you have any concerns about the conduct of this research, please contact Dr Negar Partow, Chair, Massey University Human Ethics Committee: Southern A, telephone 04 801 5799 x 63363, email humanethicsoutha@massey.ac.nz.

Research contacts:

Researcher: Siobhan Matheson

E-mail: [REDACTED]

Phone: [REDACTED]

Supervisor: Dr Kirsty Ross

E-mail: K.J.Ross@massey.ac.nz

Phone: +64 6 951 7968

Thank you in advance for taking the time to consider my request, I look forward to hearing back from you.

Kind regards,

Siobhan Matheson

Appendix E – Request for Assistance Email APS



Australian Psychological Society
Level 11, 257 Collins Street
Melbourne 3000
Victoria

RE: Master of Arts (Psychology) Research Project

Hello,

My name is Siobhan Matheson and I am currently completing a Master of Arts (Psychology) Degree at Massey University. The research I am conducting as part of my Master's is titled: How can we improve self-care practices and reduce burnout within New Zealand and Australian psychologists? Examining self-compassion and its link to self-care and burnout. This research will be conducted under the supervision of Dr Kirsty Ross, Senior Lecturer in the School of Psychology at Massey University, and Registered Clinical Psychologist. I am contacting you as I would appreciate your help in recruiting participants for my research.

I am looking for current registered and practicing New Zealand and Australian psychologists to complete an online, anonymous survey. The survey will take approximately 15 minutes to complete and includes questions on demographic factors, as well as measures on self-compassion, self-care practices, and burnout. I would be grateful if you could please consider contacting your members and advising them of the opportunity to take part in this research using the attached advertising email. I have also attached a detailed information sheet for your review and consideration.

Please let me know if you are interested and willing to help with participant recruitment. I am happy to answer any questions you may have and supply you with any additional information that you may require.

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern A, Application 22/04. If you have any concerns about the conduct of this research, please contact Dr Negar Partow, Chair, Massey University Human Ethics Committee: Southern A, telephone 04 801 5799 x 63363, email humanethicsoutha@massey.ac.nz.

Research contacts:

Researcher: Siobhan Matheson

E-mail: [REDACTED]

Phone: [REDACTED]

Supervisor: Dr Kirsty Ross

E-mail: K.J.Ross@massey.ac.nz

Phone: +64 6 951 7968

Thank you in advance for taking the time to consider my request, I look forward to hearing back from you.

Kind regards,

Siobhan Matheson

Appendix F– Participation Email



How can we improve self-care practices and reduce burnout within New Zealand and Australian psychologists? Examining self-compassion and its link to self-care and burnout.

Hello psychologists,

You are invited to participate in a study undertaken by Siobhan Matheson, a Massey University Masters research student and supervised by Dr Kirsty Ross, Senior Lecturer in the School of Psychology at Massey University, and Registered Clinical Psychologist.

The demanding nature of psychologists' work and their exposure to sensitive and distressing content puts them at risk of experiencing heightened stress and burnout. Burnout has been linked to a variety of negative outcomes both for the individual psychologist and their clients. Self-care is widely known as important for improving wellbeing and preventing negative stress outcomes such as burnout; however, few studies have systematically investigated the link between the two within psychologists. Further, despite the importance of self-care, psychologists have been found to have a chronic disregard for their own needs, often putting the needs of their clients above their own. Given the risks associated with burnout and insufficient engagement in self-care, there is a need to investigate factors that may contribute to psychologists' engagement in self-care, particularly within a NZ and Australian context.

Consequently, the purpose of this research is to investigate whether self-compassion is a factor by which psychologists' engagement in self-care practices can be increased. This research will also explore the relationship between self-care, self-compassion and burnout in NZ and Australian psychologists, investigating whether self-compassion may strengthen (moderate) the association between self-care and burnout.

Participation in this study is voluntary and involves completion of an anonymous online survey that will take approximately 15 minutes to complete. After completing the survey, you will be given the opportunity to go into a prize draw to win a \$50 voucher.

To be eligible to participate in this study, you need to be:

Registered with either the New Zealand or Australian Psychologists Board; **AND**

- Hold a current practising certificate

If you wish to participate, please click the following link to contribute to this important research.

[How can we improve self-care practices and reduce burnout within New Zealand and Australian psychologists? Examining self-compassion and its link to self-care and burnout.](#)

Thank you in advance for taking the time to consider this request.



MASSEY UNIVERSITY
COLLEGE OF HUMANITIES
AND SOCIAL SCIENCES
TE KURA PŪKENGĀ TANGATA

Please feel free to contact the researcher, Siobhan Matheson at [REDACTED], or her supervisor, Dr Kirsty Ross at K.J.Ross@massey.ac.nz if you have any questions regarding this research project,

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern A, Application 22/04. If you have any concerns about the conduct of this research, please contact Dr Negar Partow, Chair, Massey University Human Ethics Committee: Southern A, telephone 04 801 5799 x 63363, email humanethicsoutha@massey.ac.nz.

Appendix G – Ethics Approval



3/07/2022

Dear: Siobhan Matheson

Re: Ethics Application - SOA 22/04 - How can we improve self-care practices and reduce burnout within New Zealand psychologists? Examining self-compassion and its link to self-care and burnout.

Thank you for the above application that was considered by the Massey University Human Ethics Committee:

Human Ethics Southern A Committee at their meeting held on **Tuesday, 8 February 2022**

On behalf of the Committee I am pleased to advise you that the ethics of your application are approved.

Approval is for three years. If this project has not been completed within three years from the date of this letter, reapproval must be requested.

If the nature, content, location, procedures or personnel of your approved application change, please advise the Secretary of the Committee.

Yours sincerely



Professor Craig Johnson
Chair, Human Ethics Chairs' Committee and Director (Research Ethics)